A New Vision
ng Term Care
- MEETING THE NEED

Alberta

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A NEW VISION

FOR

LONG TERM CARE

- MEETING THE NEED -

February, 1988

LEGISLATIVE ASSEMBLY
ALBERTA

503 Legislature Building
EDMONTON, Alberta
T5K 2B6

February 4, 1988

TO: THE CITIZENS OF ALBERTA

The Alberta Government places high priority on long-term care and services for senior citizens. In the last 10 years, we have introduced a number of programs for the elderly, involving home care, extended health benefits, an assured income plan and home improvement programs. A new Nursing Homes Act was also brought in, followed by better programs in those homes and auxiliary hospitals.

This commitment to quality care, coupled with projected increases in the number of elderly, led to the establishment of the Long Term Care Committee on Senior Citizens. The Committee was asked to review long-term care in Alberta and to recommend measures to respond to the needs of the elderly within the resources of the Province.

The government now releases the attached discussion paper on Long Term Care. We welcome your comments in the form of a written response to this paper. Final policy will be based on a review of all submisssions.

The Government is confident that, working with you as partners in improving long-term care, we can assure a better future for Albertans.

Dianne

DIANNE MIROSH, (Mrs.), MLA
Chairman, Long Term Care Committee

Please write to: 503 Legislature Building
EDMONTON, Alberta
T5K 2B6

THE COMMITTEE ON LONG TERM CARE

FOR SENIOR CITIZENS

"Our goal is to make recommendations which foster and promote a continuum of appropriate long term care for the aging population, emphasizing independence and quality of life in a community and family-based environment, commensurate with the resources of the province and the individual."

Chairperson: Dianne Mirosh, MLA,
Calgary Glenmore

Members: Harry Alger, MLA, Highwood
Larry McDannold
Tom Biggs
Susan Green
Vivien Lai

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CHAPTER I

A NEW VISION FOR LONG TERM CARE

INTRODUCTION

Alberta is a province blessed with an abundance of natural resources. Our mountains, water and prairie lands all contribute to a rich heritage for the future of all Albertans.

Even of greater importance to our future is the compassion and understanding rooted so deeply in all of our people, and founded on the caring and strength of our pioneers and senior citizens. Coming from many walks of life, from many countries and cultures, it is these senior citizens who have built such a solid foundation for our future.

With these thoughts in mind, it is important for all of us to consider and plan for the care and well-being of our seniors in their later years of life.

Alberta has a system of long term care which is the envy of many other provinces in Canada.

Our lodges, self-contained housing units, home-improvement programs and property tax rebates for seniors are unequalled in Canada. In recent years we have rapidly developed our programs of home nursing care, homemaker services, day hospital and adult day care. The drop-in centres seniors have often built are a source of pride to us. Government-assisted transportation to cultural and recreational events is well used. Our Health Care Insurance Plan for seniors covers more basic needs than any other plan of its kind.

Thanks to our programs of developing and improving nursing homes, auxiliary hospitals and acute care hospitals, we have the most advanced system in the country. Facilities for geriatric assessment and treatment, such as the Youville Hospital in Edmonton, provide world-class services for our senior citizens.

Why then, with all of these services, do we need to review our long term care system?

Currently, just over 190,000 Albertans, or 8% of the population, are over 65 years of age. During the next 20 years that sector of the population will rise to 300,000 or 10% of the total. These population projections require us to plan now for the future needs of a growing number of senior citizens.

The concerns that arise from the growth in the number of elderly persons are accompanied by concerns about the high consumption of health care services among the elderly and about the increasing cost of institutional care. We must also balance the cost of care and services to the elderly against available resources.

In addition, the many programs and services that exist in Alberta today for senior citizens have given rise to concerns about the need for greater coordination of information and services. As this discussion paper shows, there are more than two dozen different agencies or groups involved in the delivery of services to seniors. There is a need, as well, to consider new methods of care for those persons suffering from mental disorders, particularly Alzheimer's disease.

It was against this background of concern for the increasing number of elderly and the need for coordination, that a Long Term Care Committee, chaired by Dianne Mirosh, MLA for Calgary Glenmore, was asked to assist in preparing this discussion paper on "Future Directions in Long Term Care."

The Committee was given the challenge of assessing the impact of changes in the demographic, social and health care environment over the next two decades on the long term care system in Alberta.

The Committee was also asked to develop a plan for meeting this challenge in partnership with service providers, community groups and the people of Alberta.

The proposed "New Vision for Long Term Care" presents the ideas that have been developed following consultation with various groups, associations and service providers, and is recommended for your discussion and comment.

CHAPTER 2

LONG TERM CARE SERVICES IN ALBERTA AND FUTURE DEMOGRAPHIC CHANGES

LONG TERM CARE SERVICES IN ALBERTA

For the purpose of this paper, the definition of long term care follows that adopted by the Canadian Hospital Association, namely:

> **"Long term care is an integrated mix of health, psychosocial, support and maintenance services provided on a prolonged basis, either continuously or intermittently, to individuals whose functional capacities are chronically impaired or at risk of impairment. Care is provided in the least restrictive environment possible.**
>
> **The objective of long term care is to increase or maintain the level of physical, social and psychological functioning of the individual to his or her maximum potential in order to promote functional independence and improve quality of life.**
>
> **The long term care system is the network of long term care services which flow in either direction along the continuum of care between acute and long term care institutional settings, community-based programs and services and organized services at home."**

In Alberta, long term care consists of a variety of community and institutional services. Community-based services are delivered through structured programs such as home care, day care and day hospital, as well as through a wide range of voluntary support organizations. These services may include professional nursing and rehabilitation designed to restore and maintain optimum levels of health and independent functioning. Community-based services may also include personal care and a wide range of support services such as homemaking, home help, and meals-on-wheels, which assist persons in their own homes in coping with the tasks of daily living.

The Co-ordinated Home Care Program combines elements of professional health and support services to assist persons living in an independent or semi-independent setting. The program was introduced in 1979 with a $3 million budget. In 1985/86, the program served 8,270 clients aged 65 and over, with a $27 million budget.

The provision of special housing alternatives for the elderly enables those who are no longer capable of maintaining their own homes to function in the least restrictive environment possible. These housing alternatives include lodges, senior citizens' apartments, unique homes

and seniors self-contained units. While housing is not considered to be part of the long term care system, it should be noted that between 20% and 30% of lodge residents receive home care services. Currently, 1,300 home care clients live in lodges.

At the other end of the continuum, institution-based long term care is provided in nursing homes and auxiliary hospitals throughout the province. These facilities provide shelter, board, 24-hour supervision, and varying levels of personal care, professional nursing and rehabilitation, as well as recreational and social activities. The institutional sector has grown steadily over the past 15 years. In 1971, there were 5,671 nursing home beds in 68 facilities, and 2,473 auxiliary hospital beds in 28 facilities. As of 1986, there were 7,808 beds in 87 nursing homes, and 4,243 beds in 44 auxiliary hospitals. Funding for these two programs has increased between 1978/79 and 1985/86 from $45 million to $111 million for nursing homes and from $45.8 million to $174 million for auxiliary hospitals. In addition to these facilities, the province operates three extended care facilities for psychogeriatric patients.

In total, the Alberta government spent approximately $352.6 million on long term care in 1985/86 (Table 2-1 and Figure 2-1). Of the estimated number of persons receiving long term care services in the same year, approximately 42% were served in institutions, 25% in special housing arrangements, and 33% through community-based services.

In addition to long term care services, seniors utilize a variety of other health care services, including acute hospital care, physician services and those provided by health care professionals. Seniors also receive benefits through the Alberta Aids to Daily Living and Extended Health Benefits Programs. As a result of their physical conditions, seniors require a disproportionately high degree of health care services. For example, persons over 65 years of age represent 19% of acute care patients and account for 36% of total patient days of acute care. Also, seniors use physician services at a rate twice that of the rest of the population. Specific utilization data for these programs and services are shown in Table 2-6 of Appendix I. In total, as 8.1% of the population, seniors accounted for approximately 40% of the total health care budget of $958 million (see Table 2-1).

Future Demographic Changes

As in that of the rest of the nation, Alberta's population is aging. In 1986, 191,300 persons were aged 65 and over, representing 8.1% of the province's total population. This number is expected to increase steadily over the next few decades, peaking at 663,100 or 18.2% of the total population by the year 2031 (Figures 2-3 and 2-4).

See Tables 2-1 through 2-7 in Appendix 1 for background data.

Within the general category of seniors, the sub-group 75 - 84 years of age will experience the highest growth. This group currently has a high utilization of health care services, due in large part to the onset of chronic and disabling conditions associated with aging (Tables 2-8 and 2-9, Appendix I).

As the proportion of seniors climbs to 18.2% of the population between now and the year 2031, the government, care providers, voluntary agencies and the public at large will be faced with a major challenge to ensure that the health care, residential, psychosocial and recreational needs of our seniors are met. In facing this challenge, we must assess the adequacy of our present system of service delivery and develop new directions that will ensure an optimum use of resources in meeting these needs.

A NEW VISION FOR LONG TERM CARE

1. Implement Single Point of Entry
2. Promote Wellness of Seniors
3. Increase Volunteer Input and Promote Public Support
4. Expand Community Services Through Planned Growth
5. Support Independence
6. Promote Development of Special Housing Support Services
7. Develop a Single Long Term Care Institutional System and Lower Bed Requirements
8. Enhance Geriatric and Gerontological Training of Care Providers
9. Improve Coordination

CHAPTER 3

RATIONALE:

A new perspective on long term care in Alberta is required. These are some of the challenges we will have to face over the next few years:

- to increase the capacity of the long term care system to meet the needs of the increasing number of elderly persons;
- to choose a direction suitable to the changing needs and preferences of seniors;
- to choose the direction for change that is most cost effective and commensurate with the resources of the province.

It is evident from our review of demographic projections and from meeting with service providers and seniors' groups, that the needs and preferences of the elderly are changing. Elderly people prefer to stay independent and remain at home for as long as possible. Meanwhile, the average age at the time of admission to lodges, nursing homes and auxiliary hospitals is now higher then in the past. At the same time, the health and well-being of seniors is improving. The life expectancy of Albertans is increasing. The elderly are major consumers of services and can be expected to be personally involved in the choice of services available to them.*

All of these changes indicate a need to develop a new direction for long term care that will make services available and accessible, in a cost-effective manner.

THE NEW VISION:

It is our view that the new vision for long term care should aim to

"FOSTER AND PROMOTE A CONTINUUM OF APPROPRIATE LONG TERM CARE FOR THE AGING POPULATION, EMPHASIZING INDEPENDENCE AND QUALITY OF LIFE IN A COMMUNITY AND FAMILY-BASED ENVIRONMENT, COMMENSURATE WITH THE RESOURCES OF THE PROVINCE AND THE INDIVIDUAL."

Specifically, the goals of the new vision should be as follows:

- TO DEVELOP A CLIENT-BASED LONG TERM CARE SYSTEM WHICH MEETS THE VARIOUS AND CHANGING NEEDS OF SENIORS IN A FLEXIBLE MANNER.
- TO ENHANCE THE QUALITY OF LIFE OF SENIORS BY IMPROVING THEIR HEALTH STATUS AND ACCESSIBILITY OF SERVICES.

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* Background statistics supporting these comments are shown in Tables 3-1 through 3-3 in Appendix I.

- TO FOSTER PUBLIC AWARENESS AND PARTICIPATION IN PROGRAMS FOR, AND SERVICES TO, THE ELDERLY.
- TO ENSURE THAT FAMILY AND COMMUNITY BASED SERVICES ARE GIVEN PRIORITY TO ENABLE SENIORS TO REMAIN AT HOME.
- TO ENSURE THAT QUALITY INSTITUTIONAL CARE IS AVAILABLE TO SENIORS.

In order to implement this vision, we recommend the further development and improved coordination of six components of service in the continuum of care. These services are currently available in Alberta in a variety of forms. We need to build upon the services we already have to develop a continuum of care for the elderly.

1. Health promotion and illness prevention component

   This component includes health promotion and illness prevention strategies aimed at keeping seniors healthy to avoid the need for institutional long term care. Seniors have a positive contribution to make to society; to maximize this potential, it is essential that they remain independent in later years. Marketing preventive health will be a major priority, to increase awareness among seniors and the general public as to responsibility for their own health.

2. Single point of entry component

   The aim of this component is to provide a single point of entry to all long term care services. This will enable seniors to access services when the need occurs, and would ensure that services are utilized appropriately.

3. Volunteer component

   The aim of this component is to maximize public awareness of, and support for, services for the elderly. The public should be encouraged to develop positive attitudes toward aging and toward the need for each of us to assist the elderly in whatever way possible. Volunteers, schools, community leagues, social support agencies and corporate sponsors should be encouraged to expand participation in programs for the elderly.

4. Community services component

   This component includes a variety of family and community-based services for the elderly, including home care, social support services and day programs. The aim of such programs should be to enable seniors to remain at home as an alternative to institutional placement.

5. Special housing support services component

   This component should include housing support services to the elderly to enable them to delay entry into the institutional system. Such initiatives should be privately funded.

6. Institutional* service component

This component includes the provision of institutional long term care in designated long term care centres. Institutional care should be considered only as a final choice, when community alternatives are no longer available or appropriate.

Figure 4-1 on page 15 illustrates graphically these components of service.

We are proposing that these components be considered as a continuum of care for the elderly. In addition, we are proposing that the following directions for change be adopted to bring about this new vision for long term care:

Directions for Change: New Vision for Long Term Care

1. IMPLEMENT SINGLE POINT OF ENTRY TO LONG TERM CARE AND ENSURE APPROPRIATE USE OF SERVICES

2. PROMOTE WELLNESS OF SENIORS

3. INCREASE VOLUNTEER INPUT AND PROMOTE PUBLIC SUPPORT

4. EXPAND COMMUNITY SERVICES THROUGH PLANNED GROWTH

5. SUPPORT INDEPENDENCE

6. PROMOTE DEVELOPMENT OF SPECIAL HOUSING SUPPORT SERVICES

7. DEVELOP A SINGLE LONG TERM CARE INSTITUTIONAL SYSTEM AND LOWER BED REQUIREMENTS

8. ENHANCE GERIATRIC AND GERONTOLOGICAL TRAINING OF CARE PROVIDERS

9. IMPROVE COORDINATION

The rationale for each of these directions is outlined in the following chapters. Specific recommendations for implementing these initiatives are also presented for discussion purposes.

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* Nursing homes and auxiliary hospitals are hereafter referred to as "Long Term Care Centres" (see Glossary).

CHAPTER 4

STRATEGIES TO IMPLEMENT SINGLE POINT OF ENTRY

DIRECTION NO. 1: IMPLEMENT SINGLE ENTRY TO LONG TERM CARE AND ENSURE APPROPRIATE USE OF SERVICES

Rationale:

The point of entry to the long term care system plays a vital role in ensuring accessibility and appropriate utilization of long term care services. At present, there is no single point of entry to long term care services in Alberta. All departments and agencies have their own processes for assessing eligibility to their programs.

Assessments are used to determine program eligibility rather than focussing on the needs of the clients. It is important that the assessment processes be changed so that the primary focus is ensuring that the needs of the client are appropriately met.

The rationale for the single point of entry is as follows:

- To ensure that community-based services are the first level of service being considered.
- To re-align the delivery of the system to focus on client needs.
- To ensure appropriate use of services as a means of controlling costs in the system.

Recognizing the importance of a single point of entry to long term care services, the government initiated two pilot projects in February, 1986. One of the pilot sites is located in Calgary, the other in the Foothills Health Unit (High River) area. These two pilot projects are scheduled to be completed in February, 1988.

Recommendation No. 1.1:

The pilot projects have demonstrated that having a single point of entry is a desirable feature for the long term care system, and that the concept can be implemented to adjust to a variety of situations. The following interim recommendation is based on the results from the pilot projects to date. Final results will be monitored over the next few months.

IT IS RECOMMENDED, BASED ON THE POSITIVE RESULTS FROM THE PILOT PROJECTS TO DATE, THAT PROVINCE-WIDE IMPLEMENTATION OF THE SINGLE POINT OF ENTRY BE ENCOURAGED AS SOON AS POSSIBLE. IMPLEMENTATION MAY VARY BY AREA TO ENSURE FLEXIBILITY TO RESPOND TO LOCAL NEEDS. INITIATIVES FOR IMPLEMENTATION SHOULD COME FROM THE LOCAL LEVEL.

Proposed Principles of Single Point of Entry:

1. The single point of entry should be based upon the principle that individuals wish to remain independent and care for themselves within the family and community-based environment for as long as they are able to do so. Thus, care in the long term care system should be provided at the lowest level consistent with the client's needs. Community-based services are considered to be the first level of care.

2. The single point of entry should recognize the importance of the family role in the delivery of services to the client. Throughout the assessment and placement process and the development of care plans, family members should be involved. Placement options should aim to strengthen and enhance family support.

3. The major focus of the single point of entry is to serve the needs of the client and ensure that they are appropriately met. Rights of individuals and client choices should be respected. The assessment process should have a problem-solving, client-centered approach.

4. The single point of entry should ensure that services are provided to the client in a streamlined and simplified manner. To avoid the inconvenience of dealing with a variety of assessors, assessment and placement services should be delivered by one worker. Case management should be an integral part of this process, to ensure that the client is not shuttled among care providers.

5. The single point of entry should act as gatekeeper for the long term care system, with respect to the co-ordination and delivery of long term care services.

Components of the Single Point of Entry:

1. Access to long term care services should be through a single point of entry. It is recommended that this point cover entry to the following services:

   - home care services for long term care patients in their places of residence; i.e., lodges, seniors' apartments, their own dwellings;
   - day programs and day hospital;
   - long term care centres (nursing homes and auxiliary hospitals).

   Communities may choose to expand the role of the single point of entry to include such functions as assessment of all lodge applications and referral to community mental health services.

2. Staff of the single point of entry are responsible for conducting comprehensive, multi-disciplinary assessment and placement processes for applicants for long term care services. The process should relate to the needs of the client and not the needs of the system.

3. The assessment and placement process should have an independent appeal process.

4. A volunteer component should be part of the single point of entry to ensure proper co-ordination with community and volunteer services.

5. The single point of entry should be linked to an information centre handling inquiries concerning services for senior citizens in the community.

6. The development of the single point of entry should be guided by a Regional Assessment and Placement Committee for the area, consisting of representatives from the community, institutional and volunteer sectors. The same committee should function as a planning committee to co-ordinate the requirements of long term care activities for the area.

7. Re-assessment and discharge planning should be an integral part of the assessment and placement process. Discharge planning should be initiated at the time of placement. This function should be conducted by staff working in the institutions in conjunction with staff from the single point of entry.

8. The single point of entry should be developed at the local level based on initiatives of local care providers. Existing resources should be utilized to consolidate assessment and placement activities for the area.

Figures 4-1 through 4-4 on pages 15-21 illustrate the relationships between different components of the long term care system to the single point of entry.

Proposed Structure for Implementation

It is recommended that Regional Assessment and Placement Committees be established to implement the single point of entry. Each Committee should consist of representatives drawn from voluntary, private and district nursing homes, auxiliary hospitals (which are to be renamed long term care centres), health units, acute care hospitals, lodges, Family and Community Support Services, and Regional Mental Health Councils, as well as a public member who is also a consumer of long term care services. The chair of each Committee should be appointed by the Minister. The Committees should employ staff, funded by the provincial Long Term Care Division. Provincial legislation should provide the mandate for the Committees to implement and administer the assessment and placement procedures developed by the Provincial Long Term Care Division. The chart on page 23 shows the membership and structure of these committees.

FIGURE 4-1

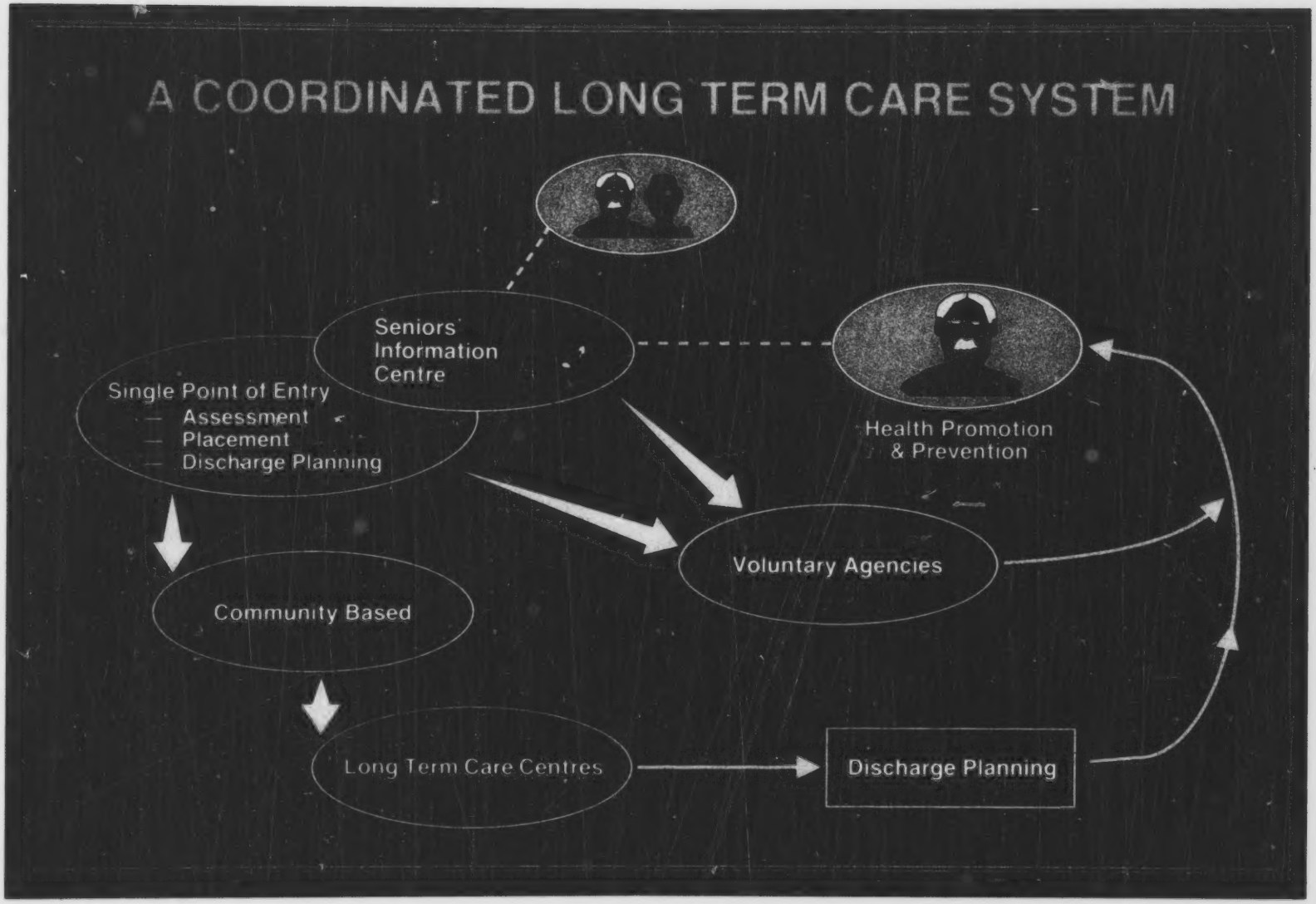

A COORDINATED LONG TERM CARE SYSTEM
Seniors Information Centre
Single Point of Entry
— Assessment
— Placement
— Discharge Planning
Health Promotion & Prevention
Voluntary Agencies
Community Based
Long Term Care Centres
Discharge Planning

FIGURE 4-2

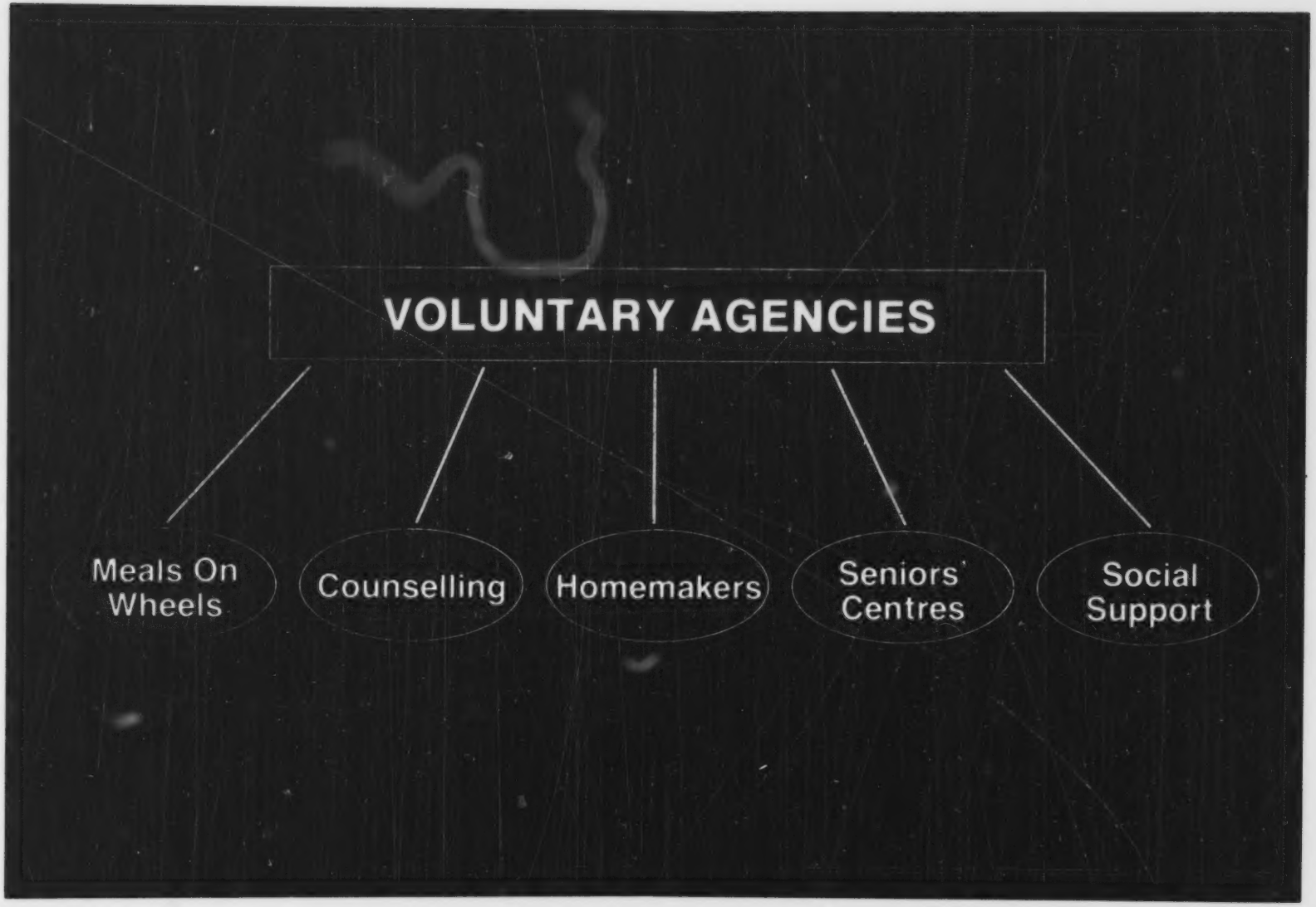

VOLUNTARY AGENCIES
Meals On Wheels
Counselling
Homemakers
Seniors' Centres
Social Support

FIGURE 4-3

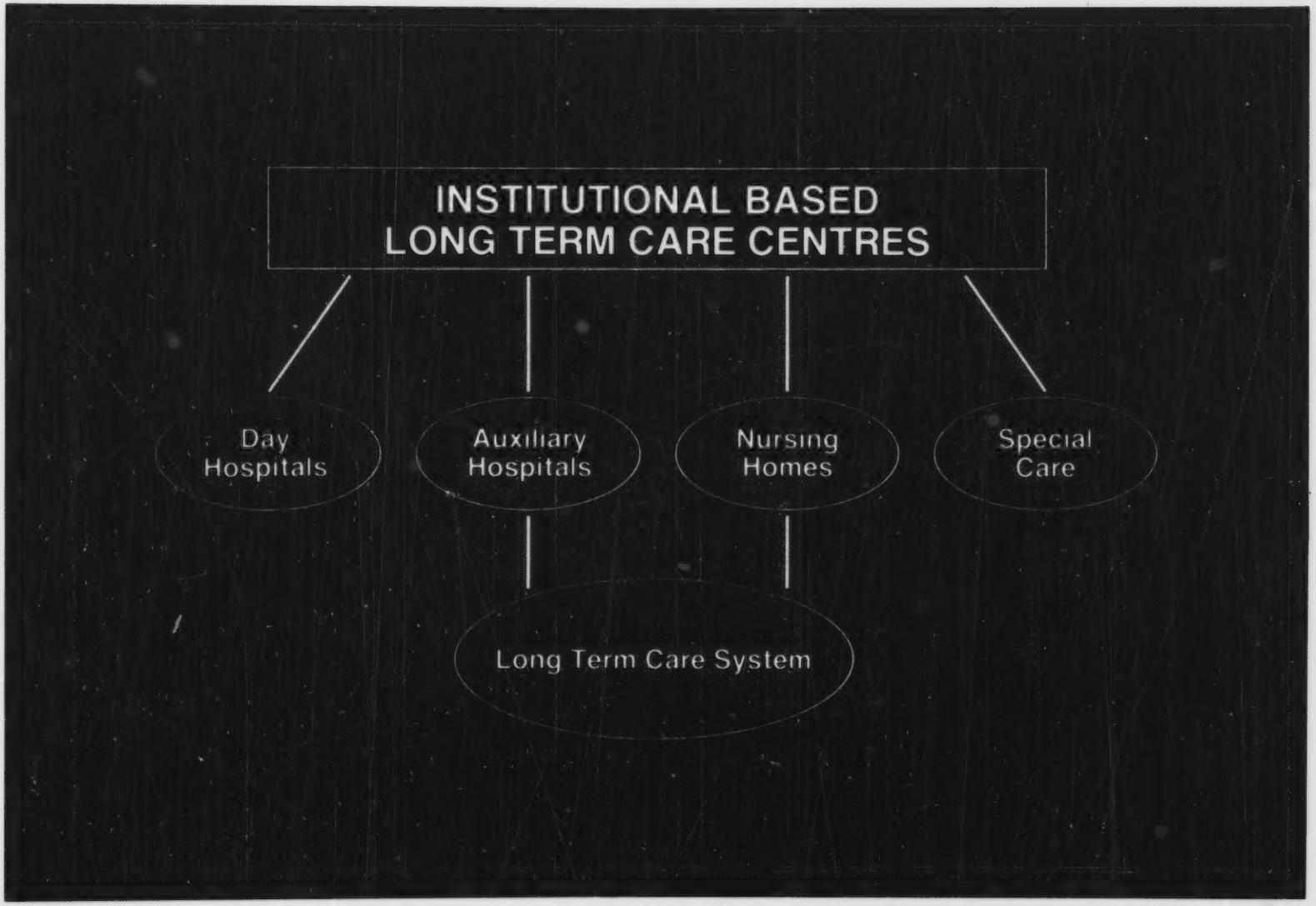
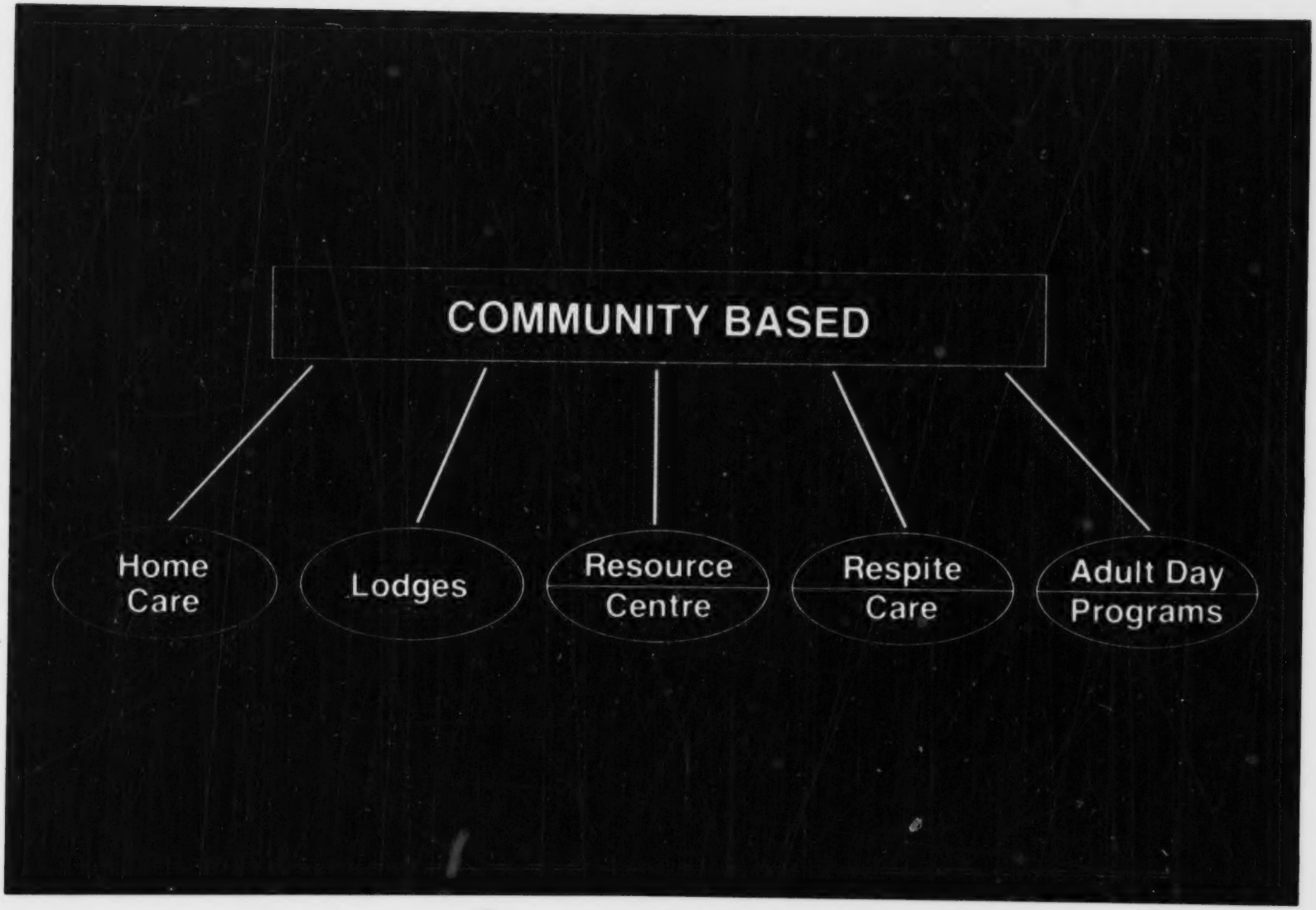

INSTITUTIONAL BASED
LONG TERM CARE CENTRES
Day Hospitals
Auxiliary Hospitals
Nursing Homes
Special Care
Long Term Care System

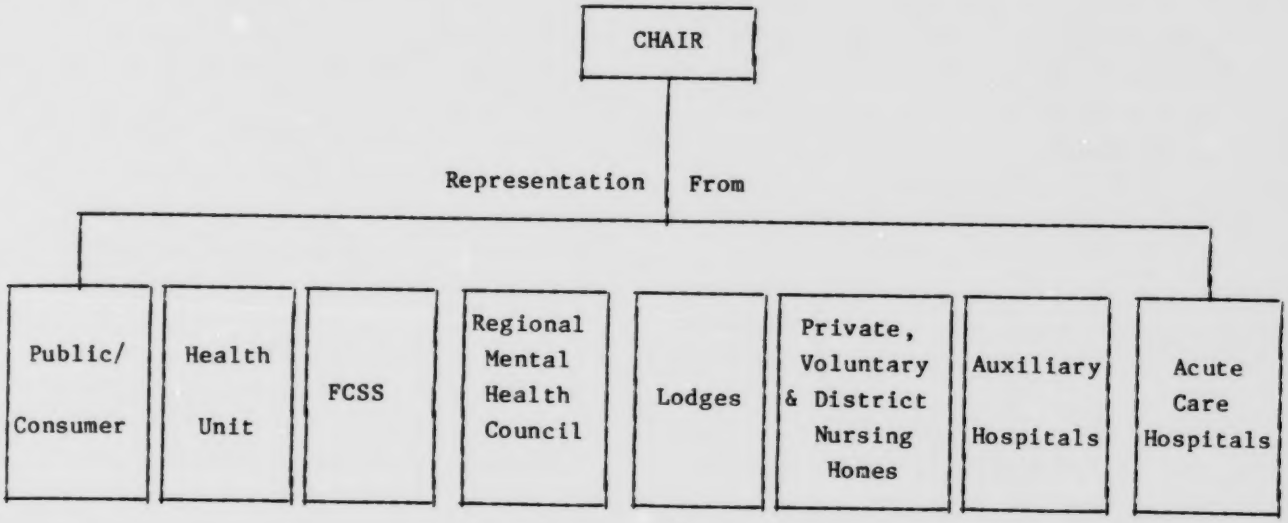
FIGURE 4-4



■ — represents institution-based

■ — represents community-based

MEMBERSHIP, REGIONAL ASSESSMENT AND PLACEMENT COMMITTEES



CHAPTER 5

STRATEGIES TO PROMOTE THE WELLNESS OF SENIORS

DIRECTION NO 2: PROMOTE WELLNESS OF SENIORS

Rationale:

The long term care givers will be challenged to meet the changing needs of the elderly. The system should be designed for the individual and should provide comprehensive long term care services. The goals ahead are not impossible to achieve. Quality care, which includes health promotion, illness prevention, wellness, skilled care and rehabilitation, is achieved when the best-known standards, resources and interventions are incorporporated.

It is not only the reponsibility, but also the obligation, of long term care providers to educate the public about the aging process in a manner that will bring understanding among the generations. Longevity has more value when there is quality to living, a sense of well-being and normalcy.

As a society, we have begun to be exposed to the degree to which we are affected by increasing lifespans, in relation to the increased mobility of the young. We are now facing the phenomenon of the old taking care of the older. The care of aging Albertans must change to increase emphasis on preventive care.

In an attempt to incorporate many of the foregoing ideas in the lifestyles of a population of elderly individuals, a new vision for long term care in this province is vital.

Planning care for the elderly must address health promotion activities and emphasize life-style changes. This discussion paper reinforces the philosophy that the elderly can and will reduce health risks if given time, information, counselling, and follow-up.

Completing surveys to assess lifestyle factors may or may not be the method of choice, but this method can serve to make persons acutely aware of wellness. Most seniors want to make changes in their lifestyles and need the opportunity of a health promotion and wellness program.

The need for community-based health promotion and primary prevention services for seniors in Alberta has been recognized by both government and voluntary health and social service agencies. In 1975, provincial funding was provided to 10 health units with the largest senior populations to develop a seniors' health program focussing on health promotion, protection, and problem prevention. To this end, a comprehensive program was implemented by Community Health Nursing which included such activities as health assessment, health promotion, identification of "at risk" seniors, protection from specific

diseases through immunization, disability prevention, health counselling, resource linkage, and referral.

This program has met with success in achieving its objectives. However, levels of service vary significantly throughout the province and further funding directed specifically towards health promotion and prevention is required.

Recommendation No. 2.1:

IT IS RECOMMENDED THAT PUBLIC EDUCATION AND HEALTH PROMOTION PROGRAMS BE FURTHER DEVELOPED TO ENHANCE THE HEALTH STATUS OF SENIORS.

2.2: FAMILY AND COMMUNITY SUPPORT SERVICES

Rationale:

A number of important home-delivered support services for frail, elderly persons are provided through the Family and Community Support Services (FCSS) program, funded jointly by the Department of Community and Occupational Health and the municipalities. As development of FCSS programs is dependent on local initiatives, there is substantial variation across the province in terms of the types of programs and services available. Some of the more common services provided through FCSS include homemaking, outreach, friendly visiting, meals-on-wheels, handyman help, counselling and transportation.

The Department of Community and Occupational Health provides funding support for municipalities sponsoring FCSS programs. Currently 110 FCSS programs operate in the province, in areas covering an estimated 90% of the population. The municipality sponsoring an FCSS project is responsible for at least 20% of the net operating costs as well as for the organization, operation, and evaluation of the project. The Coordinated Home Care Program frequently contracts with FCSS to provide support services. The continued availability of these services is crucial to meeting the needs of frail and disabled elderly persons.

Recommendation No. 2.2:

IT IS RECOMMENDED THAT SOCIAL SUPPORT PROGRAMS FUNDED BY FAMILY AND COMMUNITY SUPPORT SERVICES (FCSS) BE MAINTAINED. MUNICIPALITIES SHOULD REASSESS PRIORITIES OF PROGRAMS FOR SENIORS DELIVERED VIA FCSS AND VOLUNTEER PROGRAMS. FCSS SHOULD LINK ITS PROGRAMS AS PART OF THE CONTINUUM OF LONG TERM CARE FOR THE ELDERLY.

CHAPTER 6

STRATEGIES TO INCREASE VOLUNTEERISM AND PROMOTE PUBLIC SUPPORT

DIRECTION NO. 3: INCREASE VOLUNTEER INPUT AND PROMOTE PUBLIC SUPPORT

Rationale:

The most frequently expressed desire of senior citizens is to remain in their homes for as long as possible. "Home" becomes the most important element in the relationship of the older person with his or her community.

The volunteer sector plays a vital role in supplementing formal community services for senior citizens, thereby ensuring a more desirable quality of life while avoiding or delaying institutionalization. Admission to an institution generally occurs because family or community support is not available to meet dependence needs.

Some of the ways in which volunteers can assist seniors in independent living include: visiting, assistance with transportation/shopping/chores, delivering books/supplies/meals, and supportive counselling and compansionship. We encourage programs such as "adopt a grand-parent program" and "seniors help seniors."

We need to recognize that seniors themselves are a major source for volunteer work, and can contribute to helping other seniors through activities such as providing companionship, hospital visiting, transportation and surveillance. Since persons over 65 years of age are expected to represent 18% of the population, we need to mobilize the resources of seniors to help other seniors.

To use volunteers effectively, there should be a formal coordinator for recruitment, selection, training and ongoing supervision and support. This coordinator should be located in the single point of entry and be considered an integral part of the long term care system. The co-ordinator should be recruited by a variety of agencies such as Home Care, FCSS, or the Assessment and Placement Committee.

The corporate sector remains a largely untapped resource with respect to meeting the needs of seniors. As a result of demographic changes, the elderly population will consume a larger percentage of health care expenditure, and thus will become a major consumer force. Therefore, serving the elderly is in the corporate interest as well as in the public interest.

The corporate sector could be made fully aware of how it would benefit from contributing to the funding and delivery of services to the elderly. These activities would enhance corporate image as well as the social and economic business climate.

Volunteering improves the economic strength of a community and the country by reducing the reliance of human service agencies on tax dollars and by making services more effective. Some corporations prefer one-time group projects, or donations of supplies and equipment. Some prefer ongoing projects such as the Ronald McDonald Houses, which are sponsored by the McDonald's Restaurant chain, for family respite for cancer-stricken children.

Recommendation No. 3.1:

IT IS RECOMMENDED THAT THE VOLUNTEER SECTOR BE CONSIDERED AN INTEGRAL PART OF THE LONG TERM CARE SYSTEM. EVERY EFFORT SHOULD BE MADE TO ENSURE THAT VOLUNTEERS, COMMUNITY AGENCIES, AND CORPORATE SPONSORS CONTRIBUTE TO THE FUNDING AND DELIVERY OF SERVICES TO THE ELDERLY.

Recommendation No. 3.2:

IT IS RECOMMENDED THAT THE SINGLE POINT OF ENTRY FOR EACH LOCAL AREA INCLUDE THE VOLUNTEER COMPONENT AS AN INTEGRAL PART OF THE STRUCTURE. THE VOLUNTEER COMPONENT SHOULD DRAW UPON THE SUPPORT OF EXISTING VOLUNTEER SERVICES TO PROVIDE ASSISTANCE TO SERVICES IN LONG TERM CARE.

CHAPTER 7

STRATEGIES TO EXPAND COMMUNITY SERVICES THROUGH PLANNED GROWTH

DIRECTION NO. 4: EXPAND COMMUNITY SERVICES THROUGH PLANNED GROWTH

Rationale:

The ability of the long term care system to effectively prevent and/or delay institutionalization is dependent on the availability of sufficient resources to enable persons to remain in their own homes. Community-based programs and services are provided to a greater or lesser extent throughout the province by provincial and municipal governments, voluntary organizations and private enterprise. These programs and services are a vital component of home-delivered care to older persons who are frail and disabled. Although there is some voluntary funding, the largest source of financial support for these services is public funding.

It is generally acknowledged that there is an insufficient level of community services in Alberta. Moreover, there is little direct linking and targeting of community funds to ensure that resources are used in the most effective manner.

Recommendation No. 4.1:

> IT IS RECOMMENDED THAT COMMUNITY-BASED PROGRAMS AND SERVICES, SUCH AS HOME CARE, DAY CARE, DAY HOSPITALS AND A VARIETY OF SOCIAL SUPPORT SERVICES, BE EXPANDED OVER THE NEXT FEW YEARS THROUGH PLANNED GROWTH AND TARGETED FUNDING.

4.2: DESIGNATION OF HOME CARE FUNDS

Rationale:

The Coordinated Home Care Program was introduced on a province-wide basis in 1978 to provide universal health treatment and support services to persons living in their own homes. The program is funded by the Department of Community and Occupational Health and administered and delivered through 27 local health units throughout the province. Under the present funding arrangement, home care budget allocations to the health units are determined on a per capita basis. In 1984/85, the Coordinated Home Care Program received an additional $10 million to complete province-wide implementation and further expand the program. Despite the additional funding, the demand for home care services exceeds the supply.

The new vision for long term care proposed by this paper advocates a co-ordinated long term care system for Alberta, providing a continuum of care to its clientele. To do so, the home care program has to be

an integral part of the long term care system. Policies and priorities of the home care program should be co-ordinated with other components of long term care. All components of long term care should follow an overall, co-ordinated system direction. This means that overall policies of the home care program should be developed at the provincial level in conjunction with policies of other components of the long term care system. In addition, funds for the program have to be earmarked and protected as the amount of home care funding should be linked to the overall direction and priorities of the long term care system.

Recommendation No. 4.2:

IT IS RECOMMENDED THAT THE COORDINATED HOME CARE PROGRAM BE MADE A DESIGNATED PROGRAM OF THE HEALTH UNITS. PROGRAM FUNDS SHOULD BE EARMARKED AS NON-TRANSFERABLE TO OTHER PROGRAMS WITHIN THE JURISDICTION OF THE HEALTH UNITS. GUIDELINES AND PRIORITIES FOR THE PROGRAMS SHOULD BE STANDARDIZED AND ISSUED BY THE PROVINCIAL DEPARTMENT.

4.3: EXPANSION OF HOME CARE FUNDS

Rationale:

The Coordinated Home Care Program has grown considerably over the past five years, as evidenced by its growth in service capacity. The program has grown both in terms of client caseload and service mandate. As a consequence of trying to maintain broad service parameters within a limited budget, the program has experienced much variation in terms of service availability and levels of service. The present mandate of the Home Care program covers a fairly broad spectrum of clients. At one end of the spectrum, acting as a preventive health resource it serves people whose requirements are very light. At the other end of the spectrum, it serves clients with a high demand for nursing hours and multiple care requirements. In the absence of home care, these clients would be likely candidates for long term care centres. In times of budgetary constraint, many local Boards of Health have opted to reduce the hours of nursing care provided by Home Care, causing increased pressure on the institutional system. Clearly, it is less expensive to care for these patients in the home than in the institutional setting. There is a need to develop an innovative method of funding to target services for this client group.

Recommendation No. 4.3:

IT IS RECOMMENDED THAT FUNDING FOR THE HOME CARE PROGRAM BE EXPANDED THROUGH TARGETED FUNDING. THE FUNDS SHOULD BE TARGETED AT PERSONS REQUIRING IMMEDIATE INSTITUTIONAL PLACEMENT, AS WELL AS THOSE WHO COULD BE DISCHARGED FROM INSTITUTIONAL CARE WITH APPROPRIATE COMMUNITY SUPPORT. THIS WOULD ENTAIL AN INCREASE IN THE HOURS OF CARE PROVIDED BY HOME CARE AND OTHER COMMUNITY SERVICES.

4.4: MANAGEMENT OF TARGETED FUNDS

Rationale:

Under the new vision of long term care, home care is expected to play a vital role in reducing the institutional bed requirements of future generations of the elderly. To accomplish this goal, it is important that the expansion of home care funds is planned in conjunction with bed planning for the elderly. To facilitate this coordination of planning, the funds for all long term care programs should be consolidated within a single agency.

Recommendation No. 4.4:

> IT IS RECOMMENDED THAT THE BUDGET FOR HOME CARE FUNDS TARGETED AT PERSONS REQUIRING INSTITUTIONAL LONG TERM CARE BECOME THE RESPONSIBILITY OF A NEWLY CREATED LONG TERM CARE DIVISION, WHICH WILL HAVE THE RESPONSIBILITY OF COORDINATING ALL LONG TERM CARE PROGRAMS IN THE PROVINCE. THE LONG TERM CARE DIVISION SHOULD USE THESE TARGETED FUNDS TO CONTRACT HOME CARE SERVICES FROM THE HEALTH UNITS.

4.5: HOMEMAKER SERVICES

Rationale:

The homemaker service is an important component of the Coordinated Home Care Program. Homemaker services consist of housekeeping and, in some cases, personal care as well. These services may be provided to persons aged 65 and over regardless of whether or not they have a medical requirement. Under the Coordinated Home Care Program, arrangements for homemaker services are made at the local level through the health units. Many health units contract this service through a local agency such as FCSS. Approximately 13% of clients receiving homemaker services pay a nominal fee of $2.00 per hour. Clients receiving the Guaranteed Income Supplement are automatically exempt from paying the user fee. However, clients may arrange through the health unit and the agency to pay privately for higher levels of service. Homemakers and other social support services are necessary community-based provisions to delay entry to institutions.

Recommendation No. 4.5:

> IT IS RECOMMENDED THAT HOMEMAKER SERVICES BE EXPANDED THROUGH THE HOME CARE PROGRAM.

4.6: FEE STRUCTURE FOR HOME CARE

Rationale:

There are no charges for any of the nursing or rehabilitation services provided by the Coordinated Home Care Program. The health units charge a user fee of $2.00 per hour for home help services and $2.00 per meal to a maximum of $300 per month for clients whose incomes exceed the Guaranteed Income Supplement.

These services are heavily subsidized by the government as, in many cases, the actual cost of providing the service far exceeds the revenue from user fees. This factor limits the government's ability to provide consistent levels of service throughout the province. There is a need to ensure that home care is both available to and accessible by the public. This means that while the cost of services should continue to be within the means of those with limited incomes, those who can afford to pay the full cost to access needed services should be encouraged to do so.

Recommendation No. 4.6:

IT IS RECOMMENDED THAT THE FEE STRUCTURE FOR THE HOME CARE PROGRAM, INCLUDING FEES FOR HOME-MAKING SERVICES, BE REVIEWED TO ALLOW INCREASED RESPONSIBILITY ON THE PART OF THE CLIENT FOR COSTS FOR THESE SERVICES.

4.7: HOME-BASED CARE

Rationale:

Home-delivered care draws upon individual, family, and community resources to enable persons to remain at home for a longer period of time than would otherwise be possible. When the onset of a chronic and disabling condition renders admission to a hospital necessary, the institution is too often regarded as "a place to die". The accepted convention of spending one's last days in a hospital is a fairly modern one. With renewed interest in preserving traditional values regarding death and dying, it is timely to direct more resources toward palliative care in the home. There should be support mechanisms to encourage the development of "home hospices". Funding assistance should be made available to support initiatives involving construction and acquisition of special aids and appliances. We endorse the concept of funding through a foundation for palliative care.

Recommendation No. 4.7:

IT IS RECOMMENDED THAT, WHERE MEDICALLY FEASIBLE, THE INDIVIDUAL'S FREEDOM TO DIE AT HOME BE RECOGNIZED. PALLIATIVE CARE IN THE HOME SHOULD BE PROVIDED BY HOME CARE AND OTHER COMMUNITY AND VOLUNTEER GROUPS.

CHAPTER 8

STRATEGIES TO SUPPORT INDEPENDENCE

DIRECTION NO. 5: SUPPORT INDEPENDENCE

Rationale:

Admission to an institution is often characterized by loss of independence and functional status. When surrounded by others who are functioning at lower levels, the "sickness" role easily takes over and renders an individual helpless and in need of care. Traditionally, it is assumed that once people are admitted to an auxiliary hospital or nursing home, their will remain there for the rest of they life. Little emphasis is placed on discharging patients back into the community.

Our new vision of long term care is centred on the individual's right to remain independent for as long as possible. The seniors have become a more vocal group in recent years and have voiced, among other concerns, the desire to remain at home for as long as possible. We have a commitment to ensure that the necessary support systems are in place to enable this.

Recommendation No. 5.1:

IT IS RECOMMENDED THAT CLIENT INDEPENDENCE BE THE THEME FOR THE DELIVERY OF SERVICES WITHIN THE LONG TERM CARE SYSTEM. POLICIES RELATING TO ALL COMPONENTS OF THE SYSTEM SHOULD BE REVIEWED AND, IF NECESSARY, REVISED, TO EMPHASIZE INDEPENDENCE.

5.2: ADULT DAY PROGRAMS

Rationale:

Adult day programs are organized group programs for adults living in the community who are physically, mentally, socially, and/or emotionally impaired and who are in need of services to maintain or improve their functioning through the provision of planned therapeutic programs. Within the general category of adult day programs a broad spectrum of services is available. Adult day programs can be classified into the following 3 categories, according to the types of services offered:

1. Shorter term, intensive programs with a high emphasis on assessment, treatment and rehabilitation;*
2. Programs providing health surveillance and personal care services; and
3. Programs providing social and recreational activities.

* Commonly known as "Day Hospitals"

Programs which fall into the first category are usually located in, or adjacent to, acute care or auxiliary hospitals, the resources of which are shared. The Department of Hospitals and Medical Care currently funds five auxiliary hospital-based programs located in Calgary and Edmonton. Four of these are targeted at treatment and rehabilitation for the frail elderly, while the other program is focussed on psychogeriatric care.

The second type of program may be located in a number of community and institution-based facilities including seniors' centres, lodges and nursing homes. The last type of program should be located in community-based facilities.

Currently, there are a number of programs which fall within the latter two categories operating in various locations throughout the province. These programs are sponsored by the Department of Community and Occupational Health, individual nursing homes, and voluntary agencies.

Adult day programs play a vital role in the maintenance of optimum levels of health and functional status, thereby preventing or delaying the need for institutional care. In addition, adult programs provide relief for families and caregivers, thereby serving as a necessary "system buffer."

Recommendation No. 5.2:

IT IS RECOMMENDED THAT ADULT DAY PROGRAMS BE EXPANDED TO COMPLEMENT THE STRATEGY OF REDUCING BED REQUIREMENTS. THE SINGLE POINT OF ENTRY SYSTEM SHOULD BE USED TO ASSESS AND REFER CLIENTS TO THESE PROGRAMS.

Recommendation No. 5.3:

IT IS RECOMMENDED THAT DAY HOSPITAL PROGRAMS WHICH HAVE A TREATMENT COMPONENT BE LOCATED SOLELY IN ACUTE CARE HOSPITALS AND IN LONG TERM CARE CENTRES.

5.4: RESPITE CARE

Rationale:

Respite care, the provision of short-term relief to primary care-givers, is recognized as a necessary component of the long term care system.

Respite care is provided on a formal or an informal basis in lodges, auxiliary hospitals and nursing homes, as well as in the home. Home-based respite care is provided by an individual who goes into the home and performs daily tasks which may include shopping, accompanying/driving the client to appointments, cooking, bathing, and housekeeping for a period of time not exceeding 24 hours. Community-based respite care may include room and

board, personal care, social activities, and continuous supervision in group homes or lodges. Access to day care programs also serves as a form of community-based respite care. Institutional respite care provided in nursing homes and auxiliary and active treatment hospitals offers a full range of services including room and board, personal care, socializing opportunities and treatment programs.

It is the provision of 24-hour care and treatment services that distinguishes institutional respite care from community and in-home services. The duration of respite care should be finite. Care must be taken to ensure that patients can return to their former place of residence when services terminate. Institutional respite care is currently offered on an informal basis in auxiliary hospitals in Edmonton and Calgary as well as in several acute care hospitals throughout the province. At present, there is no formal policy for the provision of institutional respite care in Alberta, although policy options and guidelines are currently being developed by the Department of Hospitals and Medical Care.

Recommendation No. 5.4:

IT IS RECOMMENDED THAT FORMAL RESPITE CARE BEDS BE DESIGNATED IN LONG TERM CARE CENTRES TO PROVIDE RELIEF TO FAMILIES CARING FOR A FRAIL PERSON AT HOME. THE ACCOMMODATION CHARGE CURRENTLY IN PLACE IN LONG TERM CARE CENTRES SHOULD BE APPLIED TO RESPITE CARE ADMISSIONS. ACCESS TO RESPITE CARE SHOULD BE MANAGED BY THE SINGLE POINT OF ENTRY.

5.5: REASSESSMENT AND DISCHARGE PLANNING

Rationale:

The needs and care requirements of the elderly are by no means static. On the contrary, they change constantly in response to changes in health and functional status. This is where the importance of regular re-assessment and discharge planning is felt. The present long term care system does not adequately address the need for community support services to promote discharge planning.

There is a need to develop formalized service linkages between both acute care and long term care facilities and the community sector, to support discharge planning. In addition, housing programs such as the lodge program should allow patients discharged from auxiliary hospitals and nursing homes to be admitted on a priority basis to facilitate the

discharge planning process. Reassessment and discharge planning will be important components of the single entry system. Staff from the single point of entry as well as from the institutional sector should participate in the discharge planning process.

Recommendation No. 5.5:

IT IS RECOMMENDED THAT REGULAR REASSESSMENT AND ONGOING DISCHARGE PLANNING BE MADE AN IMPORTANT COMPONENT OF THE DELIVERY OF LONG TERM CARE. THE MAXIMUM PERIOD OF TIME BETWEEN ASSESSMENTS SHOULD BE ONE YEAR.

CHAPTER 9

STRATEGIES TO PROMOTE THE DEVELOPMENT OF SPECIAL HOUSING SUPPORT SERVICES

DIRECTION NO. 6: PROMOTE DEVELOPMENT OF SPECIAL HOUSING SUPPORT SERVICES

Rationale:

Although housing is not generally considered to be part of the long term care system, it plays a major role in delaying entry to institutions by providing special support services in the living environment. In Alberta, special housing for seniors is provided in lodges and senior citizens' apartments, as well as in a variety of privately-run housing complexes.

Lodges, which provide room, board and light housekeeping and laundry services, are built by the Alberta Mortgage and Housing Corporation (AMHC) and operated by municipally appointed foundations throughout the province. In addition, there are other lodges offering limited care which are owned and operated by voluntary or religious associations.

Self-contained apartment units are designed for seniors who are still capable of independent living even though they are no longer able to maintain their own homes. Such apartment buildings are located throughout Alberta and range in size from high rises to fourplexes. Some of these units are rented at a subsidized, fixed monthly rate, while others operate on a rent-geared-to-income basis. Many offer some degree of health surveillance, whether it be through an alert system or through regular rounds to check on residents.

Over the next decade, with the projected increase in the number of elderly, the demand for special housing arrangements for seniors will continue to rise. This demand is currently being met by various developers using innovative design features and support services. Such efforts should continue to be encouraged.

Recommendation No. 6.1:

IT IS RECOMMENDED THAT PRIVATE SECTOR, COMMUNITY AND NON-PROFIT INITIATIVES BE ENCOURAGED TO DEVELOP A VARIETY OF SENIORS HOUSING ALTERNATIVES. THESE WILL CONTINUE TO INCLUDE SENIOR CITIZENS' HOUSING COMPLEXES WITH HEALTH SURVEILLANCE PROGRAMS, MULTI-LEVEL CARE FACILITIES, ETC. MODERN TECHNOLOGY SHOULD BE INCORPORATED INTO THESE DEVELOPMENTS TO ENHANCE HEALTH SURVEILLANCE FOR THE FRAIL ELDERLY. ANY SUCH PROJECTS SHOULD BE FUNDED BY PRIVATE AND VOLUNTARY GROUPS.

6.2: ROLE OF LODGES

Rationale:

The lodge program experienced a major period of growth up until the mid-1970s. Since the beginning of the program in 1958, approximately 8,000 lodge beds have been established. However, since the introduction of community- based programs, the demand for lodge beds has declined considerably. High vacancy rates have become a major problem for some lodge foundations. To counteract these vacancies, a substantial effort has been made to convert existing double rooms in lodges to single rooms. As of July,1986, the number of beds had decreased to 6,753.

The role of lodges has changed significantly since the program was established. Surveys of lodges have indicated that at least 20% of the residents require some level of care and assistance and approximately30% are receiving Home Care services. This increase in dependency could be attributed to an increase in the average age of lodge residents from 75 to 83 over the past two decades. A more recent trend is the gradual decline in occupancy, particularly in rural areas where the overall vacancy rate averages 10%. The emergence of new housing alternatives and community-based support services is felt to be a major contributing factor. A number of lodges have decided to utilize existing vacant beds by providing respite care.

These trends have brought about efforts to re-examine the role of lodges and to clarify the role definition of the lodge program. The Alberta Mortgage and Housing Corporation, in conjunction with the Senior Citizens Homes Association, is presently conducting a lodge study to determine what level of personal care is being provided, what procedures are being used to handle medications and how the assessment/placement model relates to lodges. The results of this study should help to clarify how the service mandate for lodges has changed over the past few years and the resulting implications for the long term care system. It is recommended that lodges should not function as health care facilities. However, it is recognized that a significant number of residents in lodges will continue to require some level of health and personal support on an intermittent basis, and such services should be provided by the Home Care program.

Recommendation No. 6.2:

> IT IS RECOMMENDED THAT LODGES REMAIN WITHIN THE JURISDICTION OF THE MINISTER RESPONSIBLE FOR HOUSING. HEALTH CARE SERVICES FOR LODGE RESIDENTS SHOULD CONTINUE TO BE PROVIDED BY HOME CARE.

6.3: RESTRICTION IN GROWTH OF LODGE PROGRAM

Rationale:

There is a strong interdependence among all components of the housing community and the institutional long term care sector. All decisions regarding the service mandate of lodges, for example, may have broader implications for other

forms of housing for seniors. Private developers are active in promoting innovative housing designs for the elderly. That seniors prefer to remain in their own homes rather than move to a different living environment is supported by a declining demand for lodge beds.*

Recommendation No. 6.3:

IT IS RECOMMENDED THAT THE GOVERNMENT EXAMINE ITS ROLE IN THE PROVISION OF HOUSING FOR SENIORS. THERE SHOULD BE NO FURTHER EXPANSION OF THE LODGE PROGRAM RELATING TO NEW APPLICATIONS UNTIL AN EXTENSIVE REVIEW OF VARIOUS HOUSING OPTIONS HAS BEEN UNDERTAKEN. CURRENT RENOVATIONS ARE EXCLUDED FROM THIS REVIEW.

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* See Chapter 5 for a description of the operational relationship between the Single Point of Entry system and lodges.

CHAPTER 10

STRATEGIES TO DEVELOP A SINGLE LONG TERM CARE INSTITUTIONAL SYSTEM AND LOWER BED REQUIREMENTS

DIRECTION NO. 7: DEVELOP A SINGLE LONG TERM CARE INSTITUTIONAL SYSTEM AND LOWER BED REQUIREMENTS

Rationale:

The institutional long term care system in Alberta has developed through a process of evolution. Auxiliary hospitals were created in 1954 under The Hospitals Act to provide institutional services to complement those in acute care hospitals. The former Nursing Homes Act was passed in 1959 to provide a "home away from home" for residents requiring long term care. However, as a result of enhanced community services, we have found that only residents needing higher levels of care actually require institutionalization. Clients with lighter care requirements are being cared for at home. There is a need, then, to shift the institutional system to care for patients at higher levels of care.

Currently Alberta has two distinct types of institutions providing long term care: nursing homes and auxiliary hospitals. Originally, nursing homes provided only personal care and light nursing services, while auxiliary hospitals provided rehabilitation, personal care and nursing services. This was modified in 1984 when the physical therapy program was introduced in nursing homes. Today, nursing homes and auxiliary hospitals in many communities serve very similar types of long term care patients, with auxiliary hospitals still handling patients at higher levels of care. However, patients' care requirements are constantly changing. Smaller communities seldom have sufficient numbers to warrant the building of both nursing homes and auxiliary hospitals. In addition, the use of different rules and regulations in nursing homes and auxiliary hospitals is confusing to the clients they serve. As a result of these concerns there is a growing need to:

1) shift the institutional system to deal with patients at higher levels of care;

2) develop a single long term care institutional system merging the existing nursing homes and auxiliary hospitals, and

3) reduce the bed requirements for institutional care by shifting priorities to emphasize community alternatives.

Recommendations:

7.1

IT IS RECOMMENDED THAT A LONG TERM CARE ACT BE DEVELOPED TO INTEGRATE ALL ASPECTS OF THE LONG TERM CARE INSTITUTIONAL SYSTEM.

7.2

IT IS RECOMMENDED THAT NURSING HOMES AND AUXILIARY HOSPITALS BE INTEGRATED TO FORM A SINGLE LONG TERM CARE INSTITUTIONAL SYSTEM. THESE FACILITIES SHOULD BE RENAMED "LONG TERM CARE CENTRES."

7.3 PATIENT CLASSIFICATION AND FUNDING

Rationale:

Currently, nursing homes are funded on a per diem basis and auxiliary hospitals through global funding. Services provided by nursing homes and auxiliary hospitals differ considerably.* If these two types of institutions are to function as a single long term care institutional system, it is important that they be comparably funded. It is also important for the funding system to acknowledge the cost associated with the various levels of care.

Recommendation: No. 7.3:

IT IS RECOMMENDED THAT PATIENT CLASSIFICATION BE ADOPTED AND IMPLEMENTED PROVINCE-WIDE. THE CLASSIFICATION SYSTEM WILL PROVIDE CASE-MIX INFORMATION FOR FUNDING OF THE LONG TERM CARE CENTRES. INCENTIVES SHOULD BE DEVELOPED TO ENCOURAGE INSTITUTIONS TO REHABILITATE PATIENTS TO LOWER LEVELS OF CARE AND TO DISCHARGE THEM BACK INTO THE COMMUNITY.

* Table 10-1 in Appendix I compares the services currently available in nursing homes and auxiliary hospitals.

7.4: BED PLANNING

Rationale:

The Department of Hospitals and Medical Care uses a planning guideline for the construction of nursing home and auxiliary hospital beds. The current guidelines are as follows:

- 45 nursing home beds per 1,000 population over 65 years of age, and
- 25 auxiliary hospital beds per 1,000 population over 65 years of age;

This is used as a planning guideline only. In reality, as of March, 1987, there were 5,080 auxiliary beds and 7,833 nursing home beds in Alberta, translating to an actual ratio of

- 40.7 nursing home beds per thousand over 65 years of age, and
- 26.4 auxiliary hospital beds per thousand over 65 years of age.

In comparison with other provinces, Alberta had approximately 69 beds per 1,000 population over 65 years of age in 1986 and ranked seventh in the provision of long term care beds (see Table 10-2, Appendix I).

In recent years, as the institutional requirements of the elderly have changed, the demand for nursing homes and auxiliary hospital beds has also changed. The occupancy rate for nursing homes, although still very high (99.5% overall), has been decreasing slightly in the last few years, while a back-log of patients await placement in auxiliary hospitals. As of September, 1987, there were 700 patients waiting for auxiliary hospital beds in Edmonton and 200 in Calgary.

Different age cohorts within the elderly population use nursing home and auxiliary hospital beds at different rates. As of 1985/86, 17.8% of the population aged 65 to 74 years occupied nursing home and auxiliary hospital beds. The percentage is 38.3% for the age group 75 to 84 years, and 29.8% for the age group 85 years and over (see Table 10-3, Appendix I).

Nursing home and auxiliary hospital beds are expensive to construct and to operate. It cost approximately $60,000 to construct a nursing home bed in 1985/86 dollars and $81,250 to construct an auxiliary hospital bed in a free-standing facility. Per diem operating support (government portion) to nursing homes ranges from $36 to $39, depending on the size of the facility. Auxiliary hospitals are funded globally at an average cost of $110 per day. The comparative cost for home care is between $3 and $7* per day, while day hospital costs are $50 to $56 per day.

In light of the expected increase in the number of elderly, clearly we can no longer afford to build beds at the same rate as we have done in the past. The following table shows the number of beds that would have to be constructed by 1996 under three different scenarios:

1) maintaining current guidelines of 45 nursing home beds and 25 auxiliary beds per 1,000 over 65 years; and

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* Cost per day is the total cost divided by the number of days on a program.

PROJECTED REQUIREMENTS FOR NURSING HOME/AUXILIARY HOSPITAL BEDS

	1991			1996		
	Beds Needed	Beds Approved	Difference*	Beds Needed	Beds Approved	Difference*
CURRENT GUIDELINE						
Use current guidelines of 45 nursing home beds and 25 auxiliary hospital beds	15,357	14,427	(930)	17,273	14,477	(2,796)
CURRENT RATIO (ACTUAL)						
Status Quo 26.38 auxiliary hospital beds 40.67 nursing home beds	14,859	14,427	(432)	16,852	14,477	(2,375)
RECOMMENDED GUIDELINE						
Reduce guidelines to 65 beds per 1,000 over 65 years	14,380	14,427	47	16,163	14,477	(1,686)

* ( ) indicates deficit

2) maintaining the status quo of 40.67 nursing home beds and 26.38 auxiliary hospital beds per 1,000 population over 65 years.
3) lowering bed planning guidelines for long term care care beds to 65 beds per thousand population over 65 years;

This analysis points to the need to re-assess the bed planning guidelines with a view to:

- lowering the bed planning guidelines to lower the cost of the system;
- integrating nursing homes and auxiliary hospitals into a combined institutional system and directing the emphasis to meet the needs of patients with higher level care;
- making the bed planning guidelines more sensitive to the different rates of institutionalization by different groups of seniors.

Recommendations No. 7.4:

IT IS RECOMMENDED THAT THE PLANNING GUIDELINES FOR LONG TERM CARE BEDS BE LOWERED IN CONJUNCTION WITH OTHER STRATEGIES TO PROMOTE INDEPENDENCE AND TO KEEP THE ELDERLY AT HOME. THE REDUCTION SHOULD BE IMPLEMENTED IN PHASES. THE INITIAL TARGET SHOULD BE TO LOWER THE GUIDELINES TO 65 BEDS PER 1000 POPULATION 65 YEARS OF AGE AND OVER. BED PLANNING GUIDELINES SHOULD FOCUS PRIMARILY ON SENIORS OVER 80 YEARS OF AGE, YET STILL BE SENSITIVE TO THE BED REQUIREMENTS OF ALL AGE GROUPS.

7.5: LONG TERM CARE PATIENTS IN ACUTE CARE HOSPITALS

Rationale:

Due to the lack of availability of long term care beds in certain areas, there are 702 long term care patients waiting in the acute care system, accounting for 5.7% of the acute care beds (see Table 10-4, Appendix I). This situation is not acceptable, as it:

1) ties up expensive acute care beds and creates waiting lists in the acute care system, and

2) leaves the elderly in an acute care environment for a prolonged period, thus delaying their rehabilitation to a normal living environment.

Concentrated efforts are required to move these long term care patients out of the acute care system. In urban areas, where there is a high occupancy of acute care beds, such patients should be moved to home care, lodges or auxiliary hospital beds. In rural areas, where there are lower acute care occupancy rates, consideration should be given to converting the beds to long term care beds rather than building more auxiliary hospital beds.

Recommendation No. 7.5:

IT IS RECOMMENDED THAT A PILOT PROJECT BE DEVELOPED IMMEDIATELY TO ADDRESS THE SITUATION OF PATIENTS CURRENTLY IN ACUTE CARE HOSPITALS IN EDMONTON AND CALGARY WAITING FOR LONG TERM CARE. THE PILOT PROJECT SHOULD BE GIVEN APPROPRIATE FUNDING TO PROVIDE ALTERNATIVE SERVICES (E.G., HOME CARE, DAY SERVICES, OTHER HOUSING ALTERNATIVES) FOR THESE PATIENTS.

7.6: DEVELOPMENT OF A PILOT QUICK RESPONSE TEAM

Rationale:

The vast majority of long term care patients in acute care hospitals have come through the emergency departments and many have been living in their own homes prior to admission. The effect on bed utilization of the occupation of acute care beds by elderly people who are not acutely ill has been discussed previously. Of greater significance is the effect of prolonged hospital stay on the patient's condition. Frail elderly persons experience rapid loss of functional skills when left in acute care hospitals for even a few weeks. Moreover, they frequently experience a breakdown in community support systems so that there is little hope of discharge back into the community.

These factors demonstrate the need to have the appropriate systems in place to provide immediate, intensive home support services so that patients can return home once they have been treated in the emergency department. A system which has met with a great deal of success in British Columbia is the Quick Response Team which was recently established as a government-funded service following a six-month pilot project. The team, which consists of social workers and nurses, operates seven days a week and focusses its efforts on those patients who would otherwise be admitted to an acute care bed. Based on the British Columbia experience, it is believed that a similar structure in Alberta could effectively divert a significant number of patients from acute care hospital admission.

Recommendation No. 7.6:

IT IS RECOMMENDED THAT A PILOT PROJECT TO FUND A COMMUNITY-BASED "QUICK RESPONSE TEAM" BE UNDERTAKEN IN EMERGENCY DEPARTMENTS OF ACUTE CARE HOSPITALS, WITH THE OBJECTIVE OF PREVENTING UNNECESSARY ADMISSIONS OF POTENTIAL LONG TERM CARE PATIENTS TO ACUTE CARE HOSPITALS. THE PILOT PROJECT SHOULD HAVE A BUDGET TO FUND A VARIETY OF COMMUNITY-BASED SERVICE OPTIONS FOR THESE PATIENTS AS AN ALTERNATIVE TO ADMISSION TO AN ACUTE CARE HOSPITAL.

7.7: ACCOMMODATION CHARGES FOR LONG STAY PATIENTS IN ACTIVE TREATMENT HOSPITALS

Rationale:

Currently, nursing home and auxiliary hospital residents are required to pay an accommodation charge to cover a portion of the cost of room and board. It is felt that the same charge should be levied for long stay patients in acute care hospitals. This would remove any incentive there might be for patients to remain in the acute care hospital rather than being transferred to a long term care facility. This recommendation is also in keeping with the government's philosophy that long term care patients should be responsible for the cost of their room and board. To operationalize this recommendation, patients should be assessed on or before the 45th day following admission to the hospital and the accommodation charges levied on the 61st day following the assessment. The accommodation charges should be equal to those charged in long term care facilities. (As of January 1, 1987, these charges were set at $14.00/day - standard, $16.50/day - semi-private, and $20.25/day - private.)

Recommendation No. 7.7:

IT IS RECOMMENDED THAT PATIENTS IN ACUTE CARE CENTRES AWAITING PLACEMENT IN LONG TERM CARE CENTRES BE CHARGED THE STANDARD LONG TERM CARE ACCOMMODATION CHARGE 60 DAYS AFTER HAVING BEEN ASSESSED AS REQUIRING LONG TERM CARE.

7.8: REGULAR ADJUSTMENTS OF LONG TERM CARE ACCOMMODATION CHARGES

Rationale:

Historically, accommodation charges for nursing homes and auxiliary hospitals have been increased on an ad hoc basis. Thus, the increases have generally come as a surprise and are often met with opposition and criticism. Indexing accommodation charges on a regular basis according to the cost of living would allow residents and operators to know when the increases will occur and how much they will be. This would allow for advance planning in accordance with budgetary situations.

Recommendation No. 7.8:

IT IS RECOMMENDED THAT ACCOMMODATION CHARGES FOR LONG TERM CARE CENTRES BE ADJUSTED QUARTERLY TO REFLECT CHANGES IN THE COST OF LIVING. THE QUARTERLY ADJUSTMENT SHOULD BE TIED IN WITH CORRESPONDING INCREASES IN OLD AGE SECURITY AND GUARANTEED INCOME SUPPLEMENT PAYMENTS.

7.9: PROVISION OF ANNUAL STATEMENTS

Rationale:

Nursing home and auxiliary hospital residents do not pay for the entire cost of services provided by the institutions. They pay a daily accommodation charge which represents only a portion of the actual cost of the room and board. The remainder of the cost is subsidized by the government through operating grants to these institutions. To increase awareness of this situation on the part of residents of nursing homes and auxiliary hospitals, it is recommended that all residents be given a statement annually, detailing the amount of government subsidization that is given on their behalf. The statement should clearly specify that it is not for payment. It should be similar to those issued by "The Bill You Don't See" pilot project conducted in the Red Deer Regional Hospital, aimed at increasing patient awareness of the cost of acute care hospitalization.

Recommendation No. 7.9:

IT IS RECOMMENDED THAT RESIDENTS OF LONG TERM CARE CENTRES BE GIVEN A STATEMENT ANNUALLY SHOWING THE AMOUNT THE GOVERNMENT HAS PAID ON THEIR BEHALF FOR CARE IN THE CENTRES.

7.10: GERIATRIC ASSESSMENT UNITS

Rationale:

Medical services for the elderly are generally provided by family phyicians. Geriatricians are limited in number in Alberta, and in Canada as a whole. The concept of geriatric assessment units is gaining popularity as a means of attracting health care professionals who have had special training and expertise in geriatric care.

Geriatric assessment units bring together the expertise of health care professionals from a variety of disciplines such as medicine, nursing, rehabilitation medicine, social work and pharmacy, who have had special training in geriatric health care. As a result, the assessment, diagnosis, and patient care plan should reflect all of the patient's health and pycho-social needs.

Geriatric assessment units should have easy access to diagnostic and medical services provided by acute care hospitals. The units should have a qualified geriatrician on staff, as well as professionals from a variety of disciplines (nursing, rehabilitation, medicine, social work, phychology and others). The units should have a strong teaching and research component and be linked to the universities.

Recommendation 7.10:

IT IS RECOMMENDED THAT INITIALLY TWO GERIATRIC ASSESSMENT UNITS BE ESTABLISHED IN NORTHERN AND SOURTHERN ALBERTA, RESPECTIVELY. THE PRIMARY FOCUS OF THE UNITS WOULD BE TO PROVIDE COMPREHENSIVE GERIATRIC ASSESSMENT TO CLIENTS WITH SPECIALIZED AND COMPLEX CONDITIONS. THE UNITS SHOULD BE LINKED TO THE SINGLE POINT OF ENTRY TO LONG TERM CARE. FUTURE CONSIDERATION SHOULD BE GIVEN TO THE DEVELOPMENT OF ADDITIONAL ASSESSMENT UNITS THROUGHOUT THE PROVINCE IN MAJOR REGIONAL CENTRES.

7.11: MULTI-LEVEL CARE

Rationale:

People experience a great deal of trauma in later years, whether it be through loss of a loved one or through gradual deterioration of the mind and body, leading to confinement in an institution. For some, this may mean leaving not only their homes but also their community in order to receive the appropriate level of care and service. Later, they may be required, once again, to move to another location as their care requirements change. Events such as these are disruptive to both the individual and to family members who are forced to travel some distance to visit and provide support. For these reasons, the Nursing Home Review Panel recommended in 1982 that facilities with a complete range of services, including drop-in centres, apartments, lodges, and continuing care facilities, be developed, beginning with pilot projects in rural and small urban centres. This recommendation has received support from other groups. In 1986, the Provincial Senior Citizens Advisory Council advanced support for integrated care in facilities as a means of preventing moves and separations, helping people to remain in their own communities and facilitating greater response to people's needs.

In response to these recommendations, a number of combined and multi-level care facilities have been developed through both provincial government and local initiatives. In terms of planning, the jurisdictional responsibility for multi-level care facilities lies with two bodies, Alberta Hospitals and Medical Care and the Alberta Mortgage and Housing Corporation.

At present, these departments are governed by different Acts and Regulations which stipulate such conditions as building code requirements. In addition, the two departments have different funding structures, planning cycles, and review and approval procedures. This can be problematic for local agencies submitting proposals. There may also be administrative and funding problems once the building has been constructed, particularly if several levels of care are being physically integrated within one building. These constraints point to a need to standardize the policies and regulations governing the planning and administration of multi-level care projects.

Recommendation No. 7.11:

IT IS RECOMMENDED THAT MULTI-LEVEL CARE BE RECOGNIZED AS AN APPROPRIATE METHOD FOR THE DELIVERY OF LONG-TERM INSTITUTIONAL CARE. A PROCEDURAL MANUAL, WHICH OUTLINES THE STEPS THAT SHOULD BE FOLLOWED FOR THE SUBMISSION OF PROJECT PROPOSALS, SHOULD BE DEVELOPED. THE GOVERNMENT DEPARTMENTS INVOLVED SHOULD ESTABLISH A CENTRALIZED POINT OF CONTACT TO FACILITATE IMPROVED COORDINATION OF THE PROCESS.

7.12: SPECIALIZED SERVICES TO PATIENTS IN LONG TERM CARE INSTITUTIONS

Rationale:

A large segment of the elderly population requiring institutional care has physical and mental impairments warranting highly specialized care. For example, elderly persons with dementia represent a major challenge for the long term care system. Recent studies have indicated that approximately one-half of the elderly institutionalized population suffers from significant cognitive impairment. Furthermore, there may be as many elderly persons with dementia in the community as in long term care institutions. In some instances, elderly persons with dementia and accompanying behaviour problems may require specialized programs in a segregated environment. In recognition of this need, Alberta Hospitals and Medical Care recently introduced mentally dysfunctioning elderly units in three auxiliary hospitals on a pilot project basis. Two of these programs include a consultative component.

Provision of services to the elderly with dementia is a challenge which faces all care providers, including acute care hospitals, auxiliary hospitals, nursing homes, community-based programs and families. Education of consultation and outreach services would assist them in case management and program development and, in general, would support the supporters.

Other groups within the institutional population, such as the physically handicapped with rehabilitation needs, require special units and programs designed for their care. Program development for two special units (one in Edmonton and one in Calgary) for care of young, physically handicapped persons is currently underway. The programs are designed to provide opportunities for client involvement in physical, educational, vocational and social rehabilitation while fostering an independent lifestyle.

To meet this need for specialized services, it is important that auxiliary hospitals continue to develop specialized long term care programs to respond to the physical, psychological and social needs of the institutional population.

Recommendation No. 7.12:

IT IS RECOMMENDED THAT THE SPECIALIZED CARE REQUIREMENTS OF SPECIAL TARGET GROUPS IN INSTITUTIONS BE RECOGNIZED. THIS WILL INCLUDE PSYCHOGERIATRIC SERVICES AND SPECIAL CARE FOR PERSONS WITH ALZHEIMER'S DISEASE AND RELATED DISORDERS.

CHAPTER 11

STRATEGIES TO IMPROVE GERIATRIC AND GERONTOLOGICAL TRAINING FOR CARE PROVIDERS

DIRECTION NO. 8: IMPROVE GERIATRIC AND GERONTOLOGICAL TRAINING FOR CARE PROVIDERS

Rationale:

The current and projected growth of the number of elderly in Alberta has increased attention paid to the care and services associated with aging. Questions have been raised about the availability of personnel to care for the elderly and the adequacy of current training in preparing care givers to promote the independent living skills of seniors with chronic conditions or some level of functional disability.

For the most part, the elderly population uses the same types of health and social services as the rest of the population. As a result, a wide variety of care providers will be serving an increasing number of elderly. These providers include physicians, nurses, nursing assistants and aides, physical and occupational therapists, dental professionals, pharmacists, vision care professionals, social workers, podiatrists, dietitians and others.*

The elderly generally use a higher proportion of health services than does the population as a whole. As of March 1987, those 65 years and over formed 8.1% of the population, but they accounted for 15% of medical service costs. Within acute care hospitals, the elderly accounted for 36% of patient days and had lengths of stay in hospital about twice the average of those for all patients.

As the number of elderly increases in Alberta, the number and types of services required will change. This will influence future human resource requirements. In addition, a shift in service delivery from institution-based to community-based care will also affect manpower requirements. For these reasons it is important to ensure personnel supply is adequate to meet the changing direction of long term care in Alberta.

Recommendation No. 8.1:

> IT IS RECOMMENDED THAT UNIVERSITIES, COLLEGES, EMPLOYERS AND CARE PROVIDERS ACKNOWLEDGE THAT SENIORS WILL BE THE MAJOR CLIENTELE FOR HEALTH AND SOCIAL SERVICES IN THE NEXT TWO OR THREE DECADES. EFFORTS SHOULD BE MADE TO ENSURE THAT WE HAVE AN ADEQUATE SUPPLY AND MIX OF MANPOWER TO RESPOND TO THE CHANGING DIRECTION OF LONG TERM CARE.

* Further information on the number and types of care givers providing services to the elderly may be found in Tables 11-1, 11-2 and 11-3 in Appendix I.

8.2: IMPROVEMENTS IN BASIC TRAINING IN GERONTOLOGY FOR ALL HEALTH CARE AND SOCIAL SERVICE PERSONNEL

Rationale:

As most health and social service manpower groups should expect an increase in their work with the elderly, gerontological and/or geriatric training should form an integral part of their basic training. By improving understanding of the aging process, care givers may be in a better position to apply their existing skills and to work with the elderly in setting realistic clinical goals.

Training programs may be divided into three types: basic training, inservice training and continuing education. Basic training refers to education programs within post-secondary institutions (e.g., universities, colleges, vocational schools) which provide entry level training for health and social services personnel. In-service training refers to education programs offered on the job by employers to improve the skills of their staff. Continuing education refers to training for graduates of basic training programs who wish to upgrade their knowledge and skills to keep pace with current developments in their field.

A distinction exists between gerontology and geriatric medicine. Gerontology is an area of study that deals with the aging process as it affects the psychological, physiological and social aspects of human life. Geriatrics is a branch of medicine that studies age-related changes in the clinical presentation of a wide variety of diseases and conditions and the effects of age on a patient's response to different therapies (e.g., drug metabolism, nutrition, compliance, etc).

According to information collected by the Alberta Health and Social Services Disciplines Committee, a provincial interdepartmental manpower planning committee, general training programs for almost all health and social service personnel contain gerontological and/or geriatric components, ranging from a general knowledge/awareness nature to a more technical nature.

Recommendation No. 8.2:

IT IS RECOMMENDED THAT BASIC TRAINING PROGRAMS FOR CARE PROVIDERS (E.G., PHYSICIANS, NURSES, PHYSIOTHERAPISTS, OCCUPATIONAL THERAPISTS, PSYCHOLOGISTS, SOCIAL WORKERS, NURSING ASSISTANTS AND OTHERS) BE REVIEWED TO ENSURE THAT THEY CONTAIN SUFFICIENT GERONTOLOGICAL OR GERIATRIC TRAINING TO PREPARE STUDENTS TO WORK WITH THE ELDERLY IN MEETING THEIR CARE REQUIREMENTS.

8.3: IMPROVEMENTS IN IN-SERVICE TRAINING AND CONTINUING EDUCATION

Rationale:

There is a limit to the amount of gerontological and geriatric training that can be provided in basic training

programs. As a result, it is important that emphasis be given by employers, professional associations, and practitioners to providing opportunities for further education in this area. Further education could include a range of training options, from on-the-job and in-service training to continuing education programs offered by post-secondary education institutions.

The Alberta Health and Social Services Disciplines Committee completed a listing of some of the continuing education programs which are currently available in the fields of gerontology and geriatric medicine.

Recommendation No. 8.3:

IT IS RECOMMENDED THAT EMPLOYERS, IN CONJUNCTION WITH PROFESSIONAL ASSOCIATIONS, DEVELOP IN-SERVICE TRAINING PROGRAMS AND OTHER CONTINUING EDUCATION OPPORTUNITIES FOR CARE PROVIDERS TO ENHANCE THEIR UNDERSTANDING OF AND SKILLS IN CARING FOR THE ELDERLY.

8.4: PERSONAL CARE AIDES IN-SERVICE TRAINING PROGRAM

Rationale:

The training program for personal care aides, developed by Alberta Vocational Centres in conjunction with Alberta Hospitals and Medical Care and Alberta Advanced Education, is a good example of in-service education for personnel with no pre-service training. Aides form the largest proportion of staff in long-term care institutions and provide most of the "hands-on" care to patients. By promoting in-service training, employers are trying to improve the skills of aides in working with patients. Introduced as a three-year pilot project, the in-service training program uses tutors within nursing homes to help aides complete home-study and practical components of each training module.

Currently, the government is working with Alberta Vocational Centres to assess the program and to examine alternative forms of program delivery which may prove more cost-effective.

Recommendation No. 8.4:

IT IS RECOMMENDED THAT THE PILOT PROJECT ON IN-SERVICE TRAINING FOR PERSONAL CARE AIDES IN NURSING HOMES BECOME A PERMANENT PROGRAM, AND BE EXPANDED TO INCLUDE TRAINING OF PERSONAL CARE AIDES CURRENTLY WORKING IN AUXILIARY HOSPITALS. THE PROGRAM SHOULD BE EVALUATED AND NEW STRATEGIES SHOULD BE DEVELOPED FOR PERMANENT DELIVERY IN A COST-EFFECTIVE MANNER.

8.5: INSERVICE RESOURCE CENTRES

Rationale:

To assist with in-service training, the government funds resource centres in Edmonton and Calgary which provide audio-visual materials and other forms of information to in-service educators of nursing homes. As a result of the positive

response from personnel in the field, it has been suggested that the centres should become ongoing programs. The centres could also share information, and coordinate activities, with the single point of entry program.

Recommendation No. 8.5:

IT IS RECOMMENDED THAT THE IN-SERVICE RESOURCE CENTRES BECOME PERMANENT PROGRAMS. THE SCOPE OF THE CENTRES SHOULD BE EXTENDED TO PROVIDE RESOURCE MATERIALS TO HOME CARE, AS WELL AS ALL LONG TERM CARE CENTRES. THE IN-SERVICE RESOURCE CENTRES SHOULD BE LINKED TO THE "SINGLE POINT OF ENTRY" TO ENCOURAGE INFORMATION EXCHANGE.

8.6: SUPPLY OF PHYSICIANS TRAINED IN GERIATRIC MEDICINE

Rationale:

Although most of the health care needs of the elderly are provided by primary care providers, physicians trained in geriatric medicine are needed to provide clinical expertise, leadership in research, and to participate in the designing and teaching of graduate and under-graduate programs related to care of the elderly patient.

The Royal College of Physicians and Surgeons of Canada first introduced a certificate of special competence in geriatric medicine in 1978. Under the accreditation guidelines of the Royal College, geriatric medicine is recognized as a sub-specialty of internal medicine.

In 1986, the College reported the availability of 13 residency programs in geriatric medicine across Canada. Since 1981, 38 candidates have successfully completed this program.

The geriatric medicine program of the University of Alberta was located in the Edmonton General Hospital. The accreditation of this program lapsed in 1986. Discussions are currently underway concerning the development and location of another geriatric assessment centre in Calgary. Both the University of Alberta and the University of Calgary are attempting to recruit geriatricians for their established chairs in geriatric medicine.

The 1987 report of the Canadian Medical Association on Health Care for the Elderly identified a critical shortage of geriatric medicine specialists in Canada. This shortage was attributed in part to the single route of entry to the geriatric medicine program. If additional types of primary certification served as an entry route to geriatric medicine, or if geriatric medicine became a primary specialty for certification, then the number of physicians in geriatric medicine training might increase.

Recommendation No. 8.6:

IT IS RECOMMENDED THAT THE PROVINCE OF ALBERTA REQUEST THAT THE FEDERAL /PROVINCIAL ADVISORY COMMITTEE ON HEALTH HUMAN RESOURCES WORK WITH THE ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF CANADA TO IMPROVE THE CANADIAN SUPPLY OF CERTIFIED SPECIALISTS IN GERIATRIC MEDICINE.

8.7: INCENTIVES TO PHYSICIANS PROVIDING GERIATRIC CARE

Rationale:

At present, the supply of trained geriatricians in Canada is limited. Primary medical care for elderly persons is provided almost exclusively by family physicians in general practice. Many of these physicians have developed clinical expertise in geriatrics through caring for such patients.

Physicians are remunerated for attending geriatric patients at the usual fixed fee for service. This remuneration system does not address the additional time required to examine an elderly patient and, in particular, to obtain a precise chronological history.

The need to modify the Schedule of Benefits to encourage physicians to spend more time with elderly patients is endorsed by the Nursing Home Review Panel (Hyde) Report (1982), which further recommends that consideration be given to providing special incentive remuneration. It is recommended that this situation be addressed through a comprehensive review of the current practice as it relates to physicians caring for elderly patients in the home, the physician's office, and the long term care centre.

Recommendation No. 8.7:

IT IS RECOMMENDED THAT THE CHAIRS IN GERIATRIC MEDICINE AT THE UNIVERSITY OF ALBERTA AND THE UNIVERSITY OF CALGARY BE FILLED AS SOON AS POSSIBLE.

Recommendation No. 8.8:

IT IS RECOMMENDED THAT A REVIEW BE CONDUCTED TO IDENTIFY POSSIBLE INCENTIVES TO ENCOURAGE PHYSICIANS TO PROVIDE SERVICES TO THE ELDERLY WITHIN LONG TERM CARE FACILITIES AND WITHIN COMMUNITY-BASED PROGRAMS.

CHAPTER 12

STRATEGIES TO IMPROVE CO-ORDINATION

DIRECTION NO. 9: IMPROVE CO-ORDINATION

Rationale:

The foregoing chapters of this report advocate a continuum of care for the elderly. To implement this new vision, co-ordination at the provincial and the local level is extremely important. At the provincial level, responsibilities for different components of the long term care system are organized as follows:

1. Health promotion and illness prevention:
   - Community Health Services, Department of Community and Occupational Health
   - Department of Hospitals and Medical Care

2. Single point of entry pilot projects:
   - shared responsibility of the Department of Community and Occupational Health, Department of Hospitals and Medical Care and Alberta Mortgage and Housing. They are administered under the auspices of the Interdepartmental Committee on Long Term Care.

3. Volunteer component and social support services:
   - Family and Community Support Services, Department of Community and Occupational Health

4. Home Care & Community Health Services:
   - Community Health Services, Department of Community and Occupational Health

5. Day Care, Day Hospital:
   - shared responsibility of the Departments of Community and Occupational Health, and Hospitals and Medical Care

6. Lodges, self-contained apartments and other housing support programs:
   - Alberta Mortgage and Housing Corporation and Alberta Housing and Municipal Affairs

7. Nursing Homes & Auxiliary Hospitals:
   - Department of Hospitals and Medical Care

8. Mental Health Services:
   - Department of Community and Occupational Health
   - Department of Hospitals and Medical Care

9. Senior Citizens Secretariat:
   - Department of Social Services

At the local level, the following agencies and Boards have responsibilities for delivering services that are part of the long term care system.

1. Health units and home care

2. District boards

3. Nursing home and auxiliary hospital operators

4. Acute care hospitals

5. Lodge foundations and lodge operators

6. Mental health services

7. FCSS boards/advisory councils, if applicable, and the municipal councils responsible for FCSS projects

8. Volunteer agencies

9. Societies responsible for service centres and seniors' organizations

To implement this new vision of long term care, we need to orientate the priorities and attitudes of provincial and local agencies toward building this co-ordinated long term care system for Albertans, abandoning our traditional territorial concerns. A co-ordinated long term care system benefits the clients, the most important consideration. Co-ordination and co-operation should be sought throughout the system, as it is only through working together that we can make this new vision come true.

To provide leadership for implementing this new vision, we need a structure at the provincial level to give impetus to these initiatives. This structure must have the following elements:

1. A focal point for planning and implementation. The focal point should serve as the central point of contact for the field concerning a variety of activities in long term care.

2. A structure coordinating the reduction of long term care beds with expansion of community services.

3. A structure that will permit flexible use of funds in the long term care system, enabling the allocation of funds to programs that are in demand and are cost effective in providing the appropriate long term care services to the local population.

4. A structure that will permit a profile and priority for long term care services.

Recently, a review was undertaken to determine how other provinces co-ordinate their long term care services. Most provinces have a mechanism in place for that purpose. Provinces such as British Columbia, Saskatchewan and Manitoba have a Division of Continuing Care, responsible for long term care services for the province.

Recommendation 9.1:

IT IS RECOMMENDED THAT A LONG TERM CARE DIVISION BE ESTABLISHED AT THE PROVINCIAL LEVEL TO BE RESPONSIBLE FOR THE FUNDING AND COORDINATION OF ALL LONG TERM CARE PROGRAMS. THIS INCLUDES FUNDING FOR THE SINGLE POINT OF ENTRY, LONG TERM CARE CENTRES (NURSING HOMES AND AUXILIARY HOSPITALS), AND COMMUNITY SERVICES AND HOME CARE SERVICES FOR CLIENTELE REQUIRING LONG TERM CARE. THE DIVISION SHOULD CONTRACT HOME CARE SERVICES FROM THE HEALTH UNITS.

Recommendation 9.2:

IT IS RECOMMENDED THAT THE SENIOR CITIZENS' ADVISORY COUNCIL AND THE SENIOR CITIZENS' SECRETARIAT, FUNCTIONING AS INDEPENDENT BODIES, REPORT THROUGH THE MLA RESPONSIBLE FOR THEIR MATTERS TO THE SAME MINISTER WHO HEADS THE DEPARTMENT RESPONSIBLE FOR LONG TERM CARE.

An organizational chart for the proposed Long Term Care Division, and its linkages to the single point of entry, is found on pages 58 and 59.

9.3: RESEARCH AND DEVELOPMENT

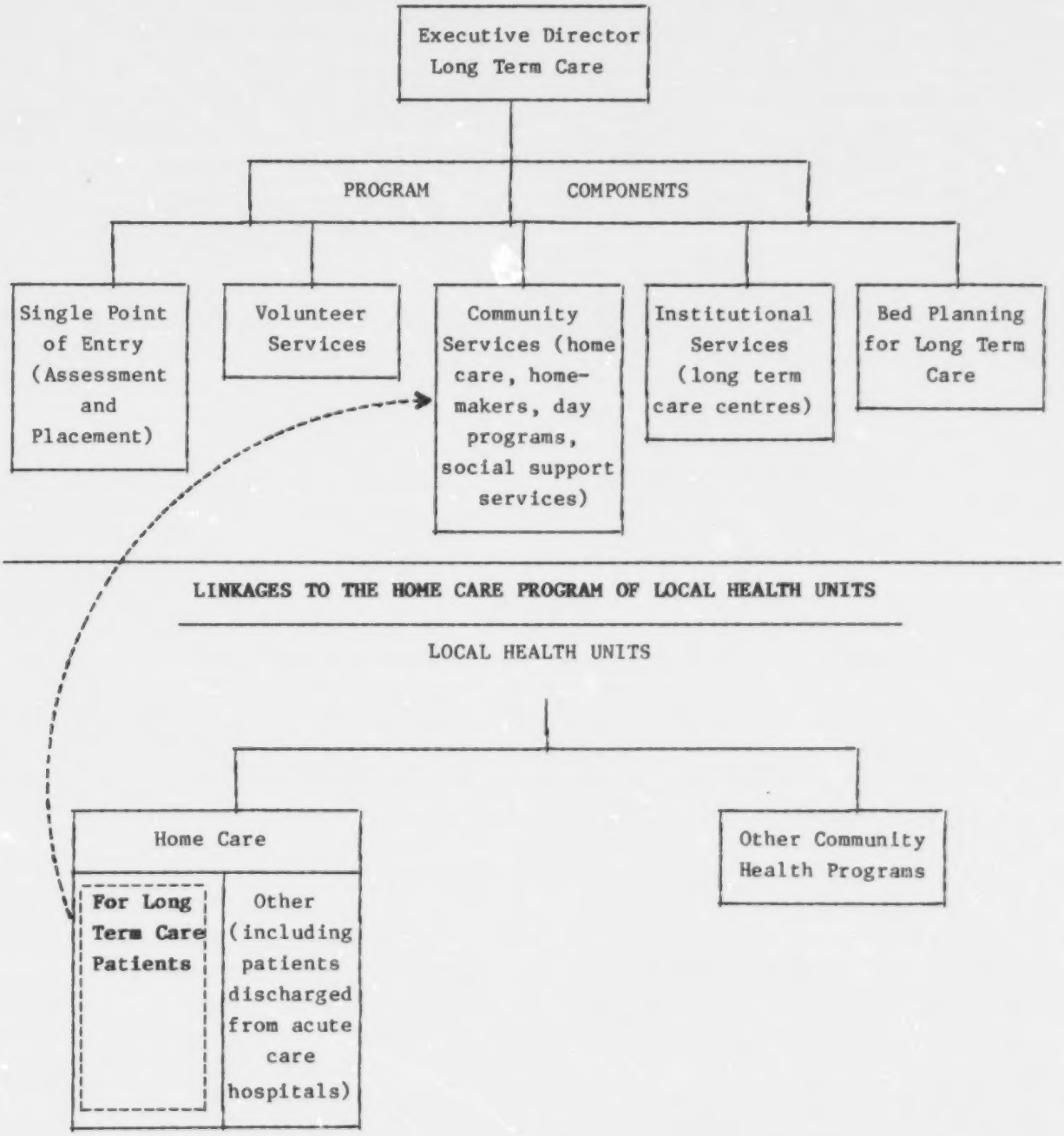
Rationale:

During the next few years, many exciting and new developments will take place in the long term care system to implement this new vision. It is important that the development of these strategies and activities be based on empirical research as well as on the collective knowledge of the long term care providers and health care experts in Alberta. Research and development activities should be launched jointly by the provincial departments and the long term care providers. This approach of joint sponsorship is evident in the development of the assessment and placement pilot projects, the assessment instrument project and the patient classification tool project. Such joint activities should be encouraged over the next five years.

Recommendation No. 9.3:

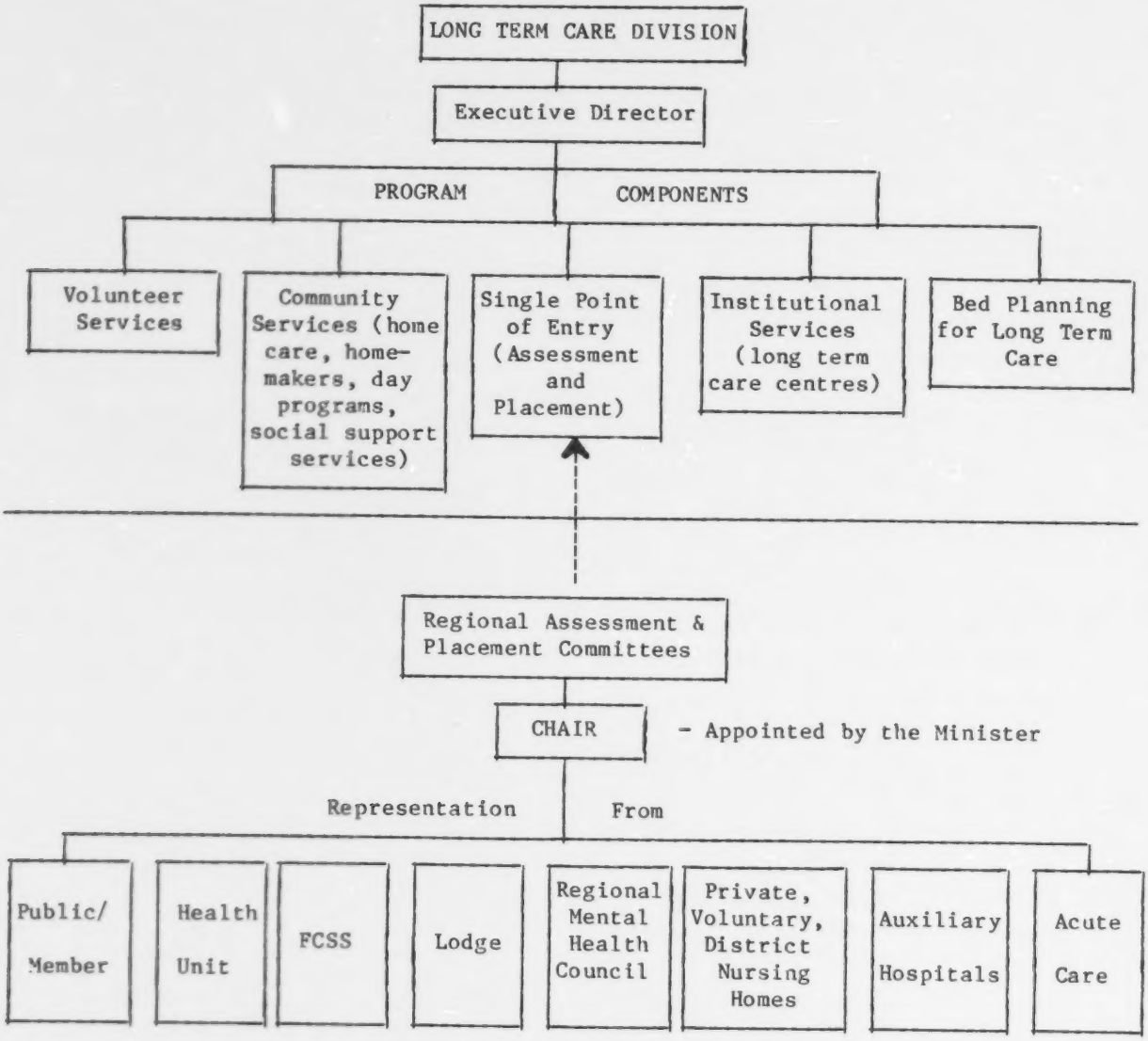
IT IS RECOMMENDED THAT RESEARCH AND DEVELOPMENT ON LONG TERM CARE PROGRAMS FOR THE ELDERLY BE ENCOURAGED AND PROMOTED. THE LONG TERM CARE DIVISION SHOULD ACTIVELY INVOLVE CARE PROVIDERS AT THE FIELD LEVEL IN RESEARCH AND INNOVATIVE PROJECTS ON LONG TERM CARE.

ORGANIZATIONAL CHART
LONG TERM CARE DIVISION


Executive Director
Long Term Care
PROGRAM
COMPONENTS
Single Point of Entry (Assessment and Placement)
Volunteer Services
Community Services (home care, home-makers, day programs, social support services)
Institutional Services (long term care centres)
Bed Planning for Long Term Care
LINKAGES TO THE HOME CARE PROGRAM OF LOCAL HEALTH UNITS
LOCAL HEALTH UNITS
Home Care
For Long Term Care Patients
Other (including patients discharged from acute care hospitals)
Other Community Health Programs

----- represents contracted services

LINKAGE BETWEEN THE LONG TERM CARE DIVISION AND SINGLE POINT OF ENTRY



CHAPTER 13
SUMMARY OF RECOMMENDATIONS

DIRECTION NO. 1: IMPLEMENT SINGLE ENTRY TO LONG TERM CARE AND ENSURE APPROPRIATE USE OF SERVICES.

Recommendation No. 1:1

IT IS RECOMMENDED, BASED ON THE POSITIVE RESULTS FROM THE PILOT PROJECTS TO DATE, THAT PROVINCE-WIDE IMPLEMENTATION OF THE SINGLE POINT OF ENTRY BE ENCOURAGED AS SOON AS POSSIBLE. IMPLEMENTATION MAY VARY BY AREA TO ENSURE FLEXIBILTY TO RESPOND TO LOCAL NEEDS. INITIATIVES FOR IMPLEMENTATION SHOULD COME FROM THE LOCAL LEVEL.

DIRECTION NO. 2: PROMOTE WELLNESS FOR SENIORS

Recommendation No. 2.1:

IT IS RECOMMENDED THAT PUBLIC EDUCATION AND HEALTH PROMOTION PROGRAMS BE FURTHER DEVELOPED TO ENHANCE THE HEALTH STATUS OF SENIORS.

Recommendation No. 2.2:

IT IS RECOMMENDED THAT SOCIAL SUPPORT PROGRAMS FUNDED BY FAMILY AND COMMUNITY SUPPORT SERVICES (FCSS) BE MAINTAINED. MUNICIPALITIES SHOULD REASSESS PRIORITIES OF PROGRAMS FOR SENIORS DELIVERED VIA FCSS AND VOLUNTEER PROGRAMS. FCSS SHOULD LINK ITS PROGRAMS AS PART OF THE CONTINUUM OF LONG TERM CARE FOR THE ELDERLY.

DIRECTION NO. 3: INCREASE VOLUNTEER INPUT AND PROMOTE PUBLIC SUPPORT

Recommendation No. 3.1:

IT IS RECOMMENDED THAT THE VOLUNTEER SECTOR BE CONSIDERED AN INTEGRAL PART OF THE LONG TERM CARE SYSTEM. EVERY EFFORT SHOULD BE MADE TO ENSURE THAT VOLUNTEERS, COMMUNITY AGENCIES AND CORPORATE SPONSORS CONTRIBUTE TO THE FUNDING AND DELIVERY OF SERVICES TO THE ELDERLY.

Recommendation No. 3.2:

IT IS RECOMMENDED THAT THE SINGLE POINT OF ENTRY FOR EACH LOCAL AREA INCLUDE THE VOLUNTEER COMPONENT AS AN INTEGRAL PART OF THE STRUCTURE. THE VOLUNTEER COMPONENT SHOULD DRAW UPON THE SUPPORT OF EXISTING VOLUNTEER SERVICES TO PROVIDE ASSISTANCE TO SERVICES IN LONG TERM CARE.

DIRECTION NO. 4: EXPAND COMMUNITY SERVICES THROUGH PLANNED GROWTH

Recommendation No. 4.1:

IT IS RECOMMENDED THAT COMMUNITY-BASED PROGRAMS AND SERVICES, SUCH AS HOME CARE, DAY CARE, DAY HOSPITALS AND A VARIETY OF SOCIAL SUPPORT SERVICES, BE EXPANDED OVER THE NEXT FEW YEARS THROUGH PLANNED GROWTH AND TARGETED FUNDING.

Recommendation No. 4.2:

IT IS RECOMMENDED THAT THE COORDINATED HOME CARE PROGRAM BE MADE A DESIGNATED PROGRAM OF THE HEALTH UNITS. PROGRAM FUNDS SHOULD BE EARMARKED AS NON-TRANSFERABLE TO OTHER PROGRAMS WITHIN THE JURISDICTION OF THE HEALTH UNITS. GUIDELINES AND PRIORITIES FOR THE PROGRAMS SHOULD BE STANDARDIZED AND ISSUED BY THE PROVINCIAL DEPARTMENT.

Recommendation No. 4.3:

IT IS RECOMMENDED THAT FUNDING FOR THE HOME CARE PROGRAM BE EXPANDED THROUGH TARGETED FUNDING. THE FUNDS SHOULD BE TARGETED AT PERSONS REQUIRING IMMEDIATE INSTITUTIONAL PLACEMENT AS WELL AS AT THOSE WHO COULD BE DISCHARGED FROM INSTITUTIONAL CARE WITH APPROPRIATE COMMUNITY SUPPORT. THIS WOULD ENTAIL AN INCREASE IN THE HOURS OF CARE PROVIDED BY HOME CARE AND OTHER COMMUNITY SERVICES.

Recommendation No. 4.4:

IT IS RECOMMENDED THAT THE BUDGET FOR HOME CARE FUNDS TARGETED AT PERSONS REQUIRING INSTITUTIONAL LONG TERM CARE BECOME THE RESPONSIBILITY OF A NEWLY CREATED LONG TERM CARE DIVISION, WHICH WILL HAVE THE RESPONSIBILITY OF COORDINATING ALL LONG TERM CARE PROGRAMS IN THE PROVINCE. THE LONG TERM CARE DIVISION SHOULD USE THESE TARGETED FUNDS TO CONTRACT HOME CARE SERVICES FROM THE HEALTH UNITS.

Recommendation No. 4.5:

IT IS RECOMMENDED THAT HOMEMAKER SERVICES BE EXPANDED THROUGH THE HOME CARE PROGRAM.

Recommendation No. 4.6:

IT IS RECOMMENDED THAT THE FEE STRUCTURE FOR THE HOME CARE PROGRAM, INCLUDING FEES FOR HOMEMAKER SERVICES, BE REVIEWED TO ALLOW INCREASED RESPONSIBILITY ON THE PART OF THE CLIENT FOR COSTS FOR THESE SERVICES.

Recommendation No. 4.7:

IT IS RECOMMENDED THAT, WHERE MEDICALLY FEASIBILE, THE INDIVIDUAL'S FREEDOM TO DIE AT HOME BE RECOGNIZED. PALLIATIVE CARE IN THE HOME SHOULD BE PROVIDED BY HOME CARE AND OTHER COMMUNITY AND VOLUNTEER GROUPS.

DIRECTION NO. 5: SUPPORT INDEPENDENCE

Recommendation No. 5.1:

IT IS RECOMMENDED THAT CLIENT INDEPENDENCE BE THE THEME FOR THE DELIVERY OF SERVICES WITHIN THE LONG TERM CARE SYSTEM. POLICIES RELATING TO ALL COMPONENTS OF THE SYSTEM SHOULD BE REVIEWED AND, IF NECESSARY, REVISED, TO EMPHASIZE INDEPENDENCE.

Recommendation No. 5.2:

IT IS RECOMMENDED THAT DAY PROGRAMS BE EXPANDED TO COMPLEMENT THE STRATEGY OF REDUCING BED REQUIREMENTS. THE SINGLE POINT OF ENTRY SYSTEM SHOULD BE USED TO ASSESS AND REFER CLIENTS TO THESE PROGRAMS.

Recommendation No. 5.3:

IT IS RECOMMENDED THAT DAY HOSPITAL PROGRAMS WHICH HAVE A TREATMENT COMPONENT SHOULD BE LOCATED SOLELY IN ACUTE CARE HOSPITALS AND IN LONG TERM CARE CENTRES.

Recommendation No. 5.4:

IT IS RECOMMENDED THAT FORMAL RESPITE CARE BEDS BE DESIGNATED IN LONG TERM CARE CENTRES TO PROVIDE RELIEF TO FAMILIES CARING FOR A FRAIL PERSON AT HOME. THE ACCOMMODATION CHARGE CURRENTLY IN PLACE IN LONG TERM CARE CENTRES SHOULD BE APPLIED TO RESPITE CARE ADMISSIONS. ACCESS TO RESPITE CARE SHOULD BE MANAGED BY THE SINGLE POINT OF ENTRY.

Recommendation No. 5.5:

IT IS RECOMMENDED THAT REGULAR REASSESSMENT AND ONGOING DISCHARGE PLANNING BE MADE AN IMPORTANT COMPONENT OF THE DELIVERY OF LONG TERM CARE. THE MAXIMUM PERIOD OF TIME BETWEEN ASSESSMENTS SHOULD BE ONE YEAR.

DIRECTION NO. 6: PROMOTE THE DEVELOPMENT OF SPECIAL HOUSING SUPPORT SERVICES

Recommendation No. 6.1:

IT IS RECOMMENDED THAT PRIVATE SECTOR, COMMUNITY AND NON-PROFIT INITIATIVES BE ENCOURAGED TO DEVELOP A VARIETY OF SENIORS HOUSING ALTERNATIVES. THESE MAY INCLUDE SENIOR CITIZENS' HOUSING COMPLEXES WITH HEALTH SURVEILLANCE PROGRAMS, MULTI-LEVEL CARE FACILITIES, ETC. MODERN TECHNOLOGY SHOULD BE INCORPORATED INTO THESE DEVELOPMENTS TO ENHANCE HEALTH SURVEILLANCE FOR THE FRAIL ELDERLY. ANY SUCH PROJECTS SHOULD BE DEVELOPED AND FUNDED BY PRIVATE AND VOLUNTEER GROUPS.

Recommendation No. 6.2:

IT IS RECOMMENDED THAT LODGES REMAIN WITHIN THE JURISDICTION OF THE MINISTER RESPONSIBLE FOR HOUSING. HEALTH CARE SERVICES FOR LODGE RESIDENTS SHOULD CONTINUE TO BE PROVIDED BY HOME CARE.

Recommendation No. 6.3:

IT IS RECOMMENDED THAT THE GOVERNMENT EXAMINE ITS ROLE IN THE PROVISION OF HOUSING FOR SENIORS. THERE SHOULD BE NO FURTHER EXPANSION OF THE LODGE PROGRAM RELATING TO NEW APPLICATIONS UNTIL AN EXTENSIVE REVIEW OF VARIOUS HOUSING OPTIONS HAS BEEN UNDERTAKEN. CURRENT RENOVATIONS ARE EXCLUDED FROM THIS REVIEW.

DIRECTION NO 7: DEVELOP A SINGLE LONG TERM CARE INSTITUTIONAL SYSTEM AND LOWER BED REQUIREMENTS

Recommendation No. 7.1:

IT IS RECOMMENDED THAT A LONG TERM CARE ACT BE DEVELOPED TO INTEGRATE ALL ASPECTS OF THE LONG TERM CARE INSTITUTIONAL SYSTEM.

Recommendation No. 7.2:

IT IS RECOMMENDED THAT NURSING HOMES AND AUXILIARY HOSPITALS BE INTEGRATED TO FORM A SINGLE LONG TERM CARE INSTITUTIONAL SYSTEM. THESE FACILITIES SHOULD BE RENAMED "LONG TERM CARE CENTRES."

Recommendation No. 7.3:

IT IS RECOMMENDED THAT PATIENT CLASSIFICATION BE ADOPTED AND IMPLEMENTED PROVINCE-WIDE. THE CLASSIFICATION SYSTEM WILL PROVIDE CASE-MIX INFORMATION FOR FUNDING OF THE LONG TERM CARE CENTRES. INCENTIVES SHOULD BE DEVELOPED TO ENCOURAGE INSTITUTIONS TO REHABILITATE PATIENTS TO LOWER LEVELS OF CARE AND TO DISCHARGE THEM BACK INTO THE COMMUNITY.

Recommendation No. 7.4:

IT IS RECOMMENDED THAT THE PLANNING GUIDELINES FOR LONG TERM CARE BEDS BE LOWERED IN CONJUNCTION WITH OTHER STRATEGIES TO PROMOTE INDEPENDENCE AND TO KEEP THE ELDERLY AT HOME. THE REDUCTION SHOULD BE IMPLEMENTED IN PHASES. THE INITIAL TARGET SHOULD BE TO LOWER THE GUIDELINES TO 65 BEDS PER 1000 POPULATION 65 YEARS OF AGE AND OVER. BED PLANNING GUIDELINES SHOULD FOCUS PRIMARILY ON SENIORS OVER 80 YEARS OF AGE, YET STILL BE SENSITIVE TO THE BED REQUIREMENTS OF ALL AGE GROUPS.

Recommendation No. 7.5:

IT IS RECOMMENDED THAT A PILOT PROJECT BE DEVELOPED IMMEDIATELY TO ADDRESS THE SITUATION OF PATIENTS CURRENTLY IN ACUTE CARE HOSPITALS IN EDMONTON AND CALGARY WAITING FOR LONG TERM CARE. THE PILOT PROJECT SHOULD BE GIVEN APPROPRIATE FUNDING TO PROVIDE ALTERNATIVE SERVICES (E.G., HOME CARE, DAY SERVICES, OTHER HOUSING ALTERNATIVES) FOR THESE PATIENTS.

Recommendation 7.6:

IT IS RECOMMENDED THAT A PILOT PROJECT TO FUND A COMMUNITY-BASED "QUICK RESPONSE TEAM" BE UNDERTAKEN IN EMERGENCY DEPARTMENTS OF ACUTE CARE HOSPITALS WITH THE OBJECTIVE OF PREVENTING UNNECESSARY ADMISSIONS OF POTENTIAL LONG TERM CARE PATIENTS TO ACUTE CARE HOSPITALS. THE PILOT PROJECT SHOULD HAVE A BUDGET TO FUND A VARIETY OF COMMUNITY-BASED SERVICE OPTIONS FOR THESE PATIENTS AS AN ALTERNATIVE TO ADMISSION TO AN ACUTE CARE HOSPITAL.

Recommendation No. 7.7:

IT IS RECOMMENDED THAT PATIENTS IN ACUTE CARE HOSPITALS AWAITING PLACEMENT IN LONG TERM CARE CENTRES BE CHARGED THE STANDARD LONG TERM CARE ACCOMMODATION CHARGE 60 DAYS AFTER HAVING BEEN ASSESSED AS REQUIRING LONG TERM CARE.

Recommendation No. 7.8:

IT IS RECOMMENDED THAT ACCOMMODATION CHARGES FOR LONG TERM CARE CENTRES BE ADJUSTED QUARTERLY TO REFLECT CHANGES IN THE COST OF LIVING. THE QUARTERLY ADJUSTMENT SHOULD BE TIED IN WITH CORRESPONDING INCREASES IN OLD AGE SECURITY AND GUARANTEED INCOME SUPPLEMENT PAYMENTS.

Recommendation No. 7.9:

IT IS RECOMMENDED THAT RESIDENTS OF LONG TERM CARE CENTRES BE GIVEN A STATEMENT ANNUALLY SHOWING THE AMOUNT THE GOVERNMENT HAS PAID ON THEIR BEHALF FOR CARE IN THE CENTRES.

Recommendation No. 7.10:

IT IS RECOMMENDED THAT INITIALLY TWO GERIATRIC ASSESSMENT UNITS BE ESTABLISHED IN NORTHERN AND SOUTHERN ALBERTA, RESPECTIVELY. THE PRIMARY FOCUS OF THE UNITS WOULD BE TO PROVIDE COMPREHENSIVE GERIATRIC ASSESSMENT TO CLIENTS WITH SPECIALIZED AND COMPLEX CONDITIONS. THE UNITS SHOULD BE LINKED TO THE SINGLE POINT OF ENTRY TO LONG TERM CARE. FUTURE CONSIDERATION SHOULD BE GIVEN TO THE DEVELOPMENT OF ADDITIONAL ASSESSMENT UNITS THROUGHOUT THE PROVINCE IN MAJOR REGIONAL CENTRES.

Recommendation No. 7.11:

IT IS RECOMMENDED THAT MULTI-LEVEL CARE BE RECOGNIZED AS AN APPROPRIATE METHOD FOR THE DELIVERY OF LONG-TERM INSTITUTIONAL CARE. A PROCEDURAL MANUAL, WHICH OUTLINES THE STEPS THAT SHOULD BE FOLLOWED FOR THE SUBMISSION OF PROJECT PROPOSALS, SHOULD BE DEVELOPED. THE GOVERNMENT DEPARTMENTS INVOLVED SHOULD ESTABLISH A CENTRALIZED POINT OF CONTACT TO FACILITATE IMPROVED COORDINATION OF THE PROCESS.

Recommendation No. 7.12:

IT IS RECOMMENDED THAT THE SPECIALIZED CARE REQUIREMENTS OF SPECIAL TARGET GROUPS IN INSTITUTIONS BE RECOGNIZED. THIS WILL INCLUDE PSYCHOGERIATRIC SERVICES AND SPECIAL CARE FOR PERSONS WITH ALZHEIMER'S DISEASE AND RELATED DISORDERS.

DIRECTION NO. 8: IMPROVE GERIATRIC AND GERONTOLOGICAL TRAINING FOR CARE PROVIDERS

Recommendation No. 8.1:

IT IS RECOMMENDED THAT UNIVERSITIES, COLLEGES, EMPLOYERS AND CARE PROVIDERS ACKNOWLEDGE THAT SENIORS WILL BE THE MAJOR CLIENTELE FOR HEALTH AND SOCIAL SERVICES IN THE NEXT TWO OR THREE DECADES. EFFORTS SHOULD BE MADE TO ENSURE THAT THERE IS AN ADEQUATE SUPPLY AND MIX OF MANPOWER TO RESPOND TO THE CHANGING DIRECTION OF LONG TERM CARE.

Recommendation No. 8.2:

IT IS RECOMMENDED THAT BASIC TRAINING PROGRAMS FOR CARE PROVIDERS (E.G., PHYSICIANS, NURSES, PHYSIOTHERAPISTS, OCCUPATIONAL THERAPISTS, PSYCHOLOGISTS, SOCIAL WORKERS, NURSING ASSISTANTS AND OTHERS) BE REVIEWED TO ENSURE THAT THEY CONTAIN SUFFICIENT GERIATRIC OR GERONTOLOGY TRAINING TO PREPARE STUDENTS TO WORK WITH THE ELDERLY IN MEETING THEIR CARE REQUIREMENTS.

Recommendation No. 8.3:

IT IS RECOMMENDED THAT EMPLOYERS, IN CONJUNCTION WITH PROFESSIONAL ASSOCIATIONS, DEVELOP IN-SERVICE TRAINING PROGRAMS AND OTHER CONTINUING EDUCATION OPPORTUNITIES FOR CARE PROVIDERS TO ENHANCE THEIR UNDERSTANDING OF AND SKILLS IN CARING FOR THE ELDERLY.

Recommendation No. 8.4:

IT IS RECOMMENDED THAT THE PILOT PROJECT ON IN-SERVICE TRAINING FOR PERSONAL CARE AIDES IN NURSING HOMES BECOME A PERMANENT PROGRAM, AND BE EXPANDED TO INCLUDE TRAINING OF PERSONAL CARE AIDES CURRENTLY WORKING IN AUXILIARY HOSPITALS. THE PROGRAM SHOULD BE EVALUATED AND NEW STRATEGIES SHOULD BE DEVELOPED FOR PERMANENT DELIVERY IN A COST-EFFECTIVE MANNER.

Recommendation No. 8.5:

IT IS RECOMMENDED THAT THE IN-SERVICE RESOURCE CENTRES BECOME PERMANENT PROGRAMS. THE SCOPE OF THE CENTRES SHOULD BE EXTENDED TO PROVIDE RESOURCE MATERIALS TO HOME CARE AS WELL AS ALL LONG TERM CARE CENTRES. THE IN-SERVICE RESOURCE CENTRES SHOULD BE LINKED TO THE "SINGLE POINT OF ENTRY" TO ENCOURAGE INFORMATION EXCHANGE.

Recommendation No. 8.6:

IT IS RECOMMENDED THAT THE PROVINCE OF ALBERTA REQUEST THAT THE FEDERAL/PROVINCIAL ADVISORY COMMITTEE ON HEALTH HUMAN RESOURCES WORK WITH THE ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF CANADA TO IMPROVE THE CANADIAN SUPPLY OF CERTIFIED SPECIALISTS IN GERIATRIC MEDICINE.

Recommendation No. 8.7:

IT IS RECOMMENDED THAT THE CHAIRS IN GERIATRIC MEDICINE AT THE UNIVERSITY OF ALBERTA AND THE UNIVERSITY OF CALGARY BE FILLED AS SOON AS POSSIBLE.

Recommendation No. 8.8:

IT IS RECOMMENDED THAT A REVIEW BE CONDUCTED TO IDENTIFY POSSIBLE INCENTIVES TO ENCOURAGE PHYSICIANS TO PROVIDE SERVICES TO THE ELDERLY WITHIN LONG TERM CARE FACILITIES AND WITHIN COMMUNITY-BASED PROGRAMS.

DIRECTION NO. 9: IMPROVE COORDINATION

Recommendation No. 9.1:

IT IS RECOMMENDED THAT A LONG TERM CARE DIVISION BE ESTABLISHED AT THE PROVINCIAL LEVEL TO BE RESPONSIBLE FOR THE FUNDING AND COORDINATION OF ALL LONG TERM CARE PROGRAMS. THIS INCLUDES FUNDING FOR THE SINGLE POINT OF ENTRY, LONG TERM CARE CENTRES (NURSING HOMES AND AUXILIARY HOSPITALS), AND COMMUNITY AND HOME CARE SERVICES FOR CLIENTELE REQUIRING LONG TERM CARE. THE DIVISION SHOULD CONTRACT HOME CARE SERVICES FROM THE HEALTH UNITS.

Recommendation No. 9.2:

IT IS RECOMMENDED THAT THE SENIOR CITIZENS' ADVISORY COUNCIL AND THE SENIOR CITIZENS' SECRETARIAT, FUNCTIONING AS INDEPENDENT BODIES REPORT THROUGH THE MLA RESPONSIBLE FOR THEIR MATTERS TO THE SAME MINISTER WHO HEADS THE DEPARTMENT RESPONSIBLE FOR LONG TERM CARE.

Recommendation No. 9.3:

IT IS RECOMMENDED THAT RESEARCH AND DEVELOPMENT ON LONG TERM CARE PROGRAMS AND SERVICES FOR THE ELDERLY BE ENCOURAGED AND PROMOTED. THE LONG TERM CARE DIVISION SHOULD ACTIVELY INVOLVE CARE PROVIDERS AT THE FIELD LEVEL IN RESEARCH AND INNOVATIVE PROJECTS IN LONG TERM CARE.

APPENDIX I

STATISTICAL TABLES

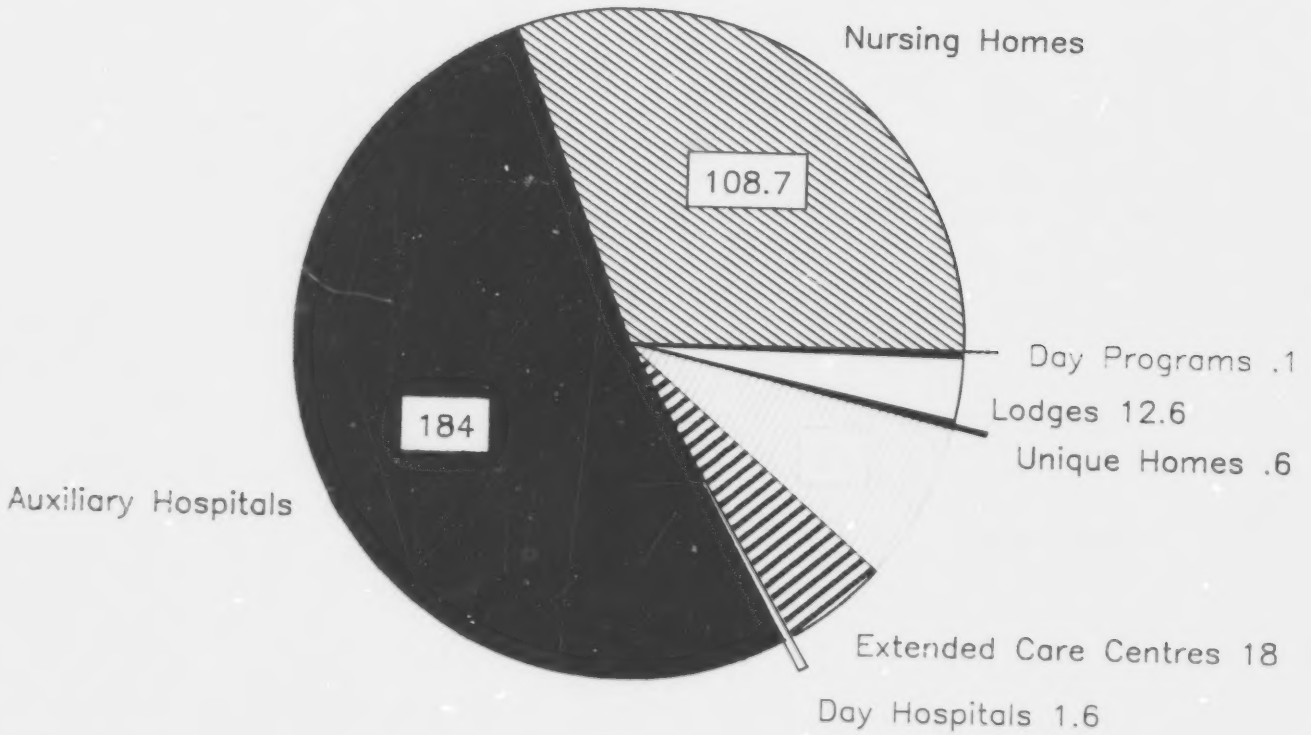
AND GRAPHS

TABLE 2-1: OPERATING BUDGET
FOR LONG TERM CARE SERVICES IN 1985/86
($ MILLIONS)

Alberta Hospitals and Medical Care		
Nursing Homes	$108.7	30.83%
Auxiliary Hospitals	184.0	51.18%
Day Hospitals	1.6	.45%
Alberta Community and Occupational Health		
Extended Care Centres	$ 18.0	5.10%
Home Care	27.0	7.60%
Day Programs	0.1	.03%
Alberta Municipal Affairs and Alberta Mortgage and Housing Corporation		
Unique Homes	$ 0.6	.17%
Lodges	12.6	3.57%
TOTAL	$352.6	100%

Percentages may not add up due to rounding.

FIGURE 2-1
OPERATING BUDGET FOR LONG TERM CARE IN 1985/86
($ Millions)



Total = $352.6 Million

TABLE 2-2: MAJOR HEALTH CARE PROGRAM EXPENDITURES FOR SENIORS IN 1985/86

($ MILLIONS)

	65+	Total	65+ as % of Total
Long Term Care Institutions[1]	$287.7	$380.1	75.6
Community-Based Services[2]	26.1	30.7	85.0
Acute Care Hospitals	437.2	1,249.2	35.0
Physician Services	82.2	549.9	14.9
Non-Physician Services[3]	124.9	188.7	66.1
TOTAL[4]	$958.1	$2,398.6	39.9%

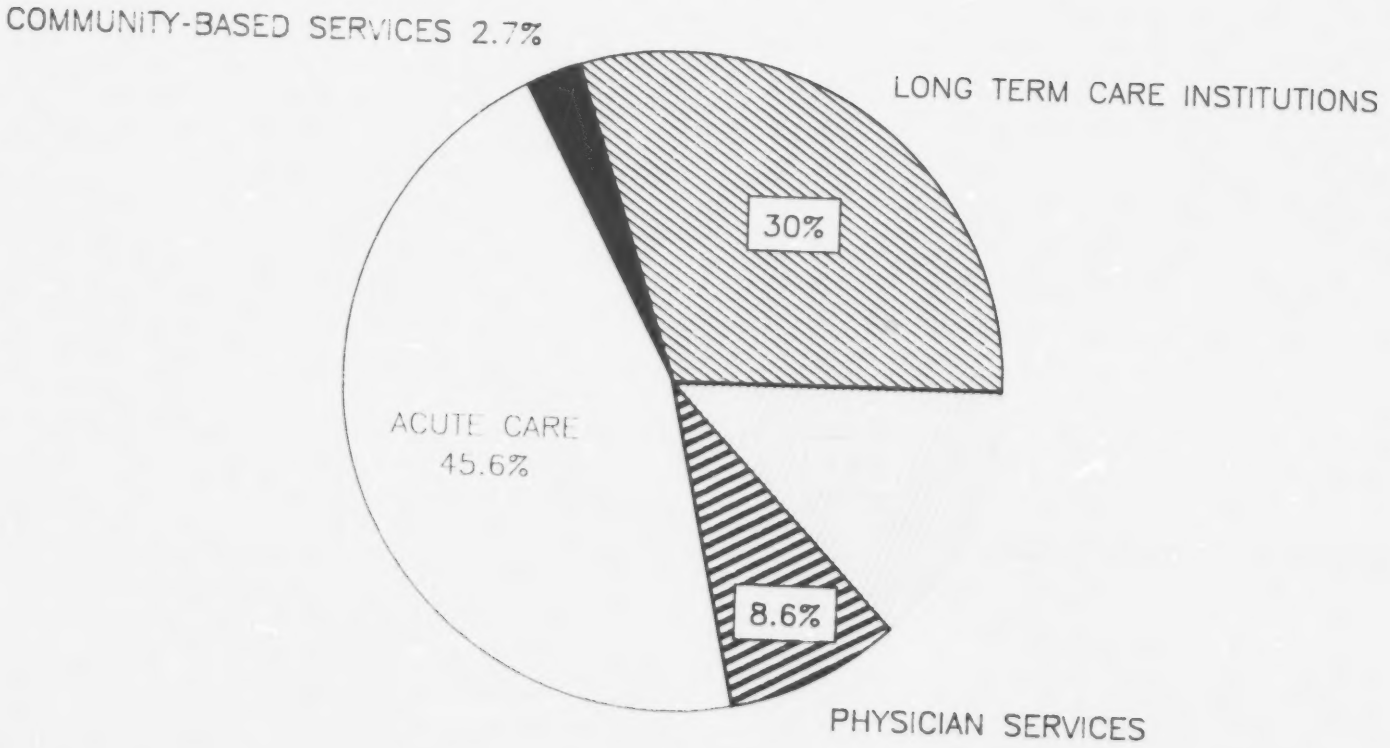
1 Includes auxiliary hospitals, nursing homes, mental health hospitals and extended care facilities.

2 Includes home care, family and community support services, day hospitals and day programs; based on an estimate of the proportion of seniors served in these programs.

3 Includes payments for basic health services delivered in and out-of-province (podiatry, physical therapy, optometry, chiropractic); extended health benefits (optometry and dental); Blue Cross and Aids to Daily Living benefits.

4 Total budget of approximately $2.4 billion includes selected programs and services delivered by the Alberta Hospitals and Medical Care and Alberta Community and Occupational Health. Vote 1, Departmental Support, is not included. This table is not a comprehensive listing of all health care programs of the province. Seniors may account for a large portion of health care spending in areas beyond those listed here.

FIGURE 2-2
DISTRIBUTION OF HEALTH CARE EXPENDITURES FOR SENIORS IN 1985/86
(Percent)



Total = $958.1 Million

FIGURE 2-3
COST OF HEALTH CARE FOR SENIORS
1985/86
($ Millions)

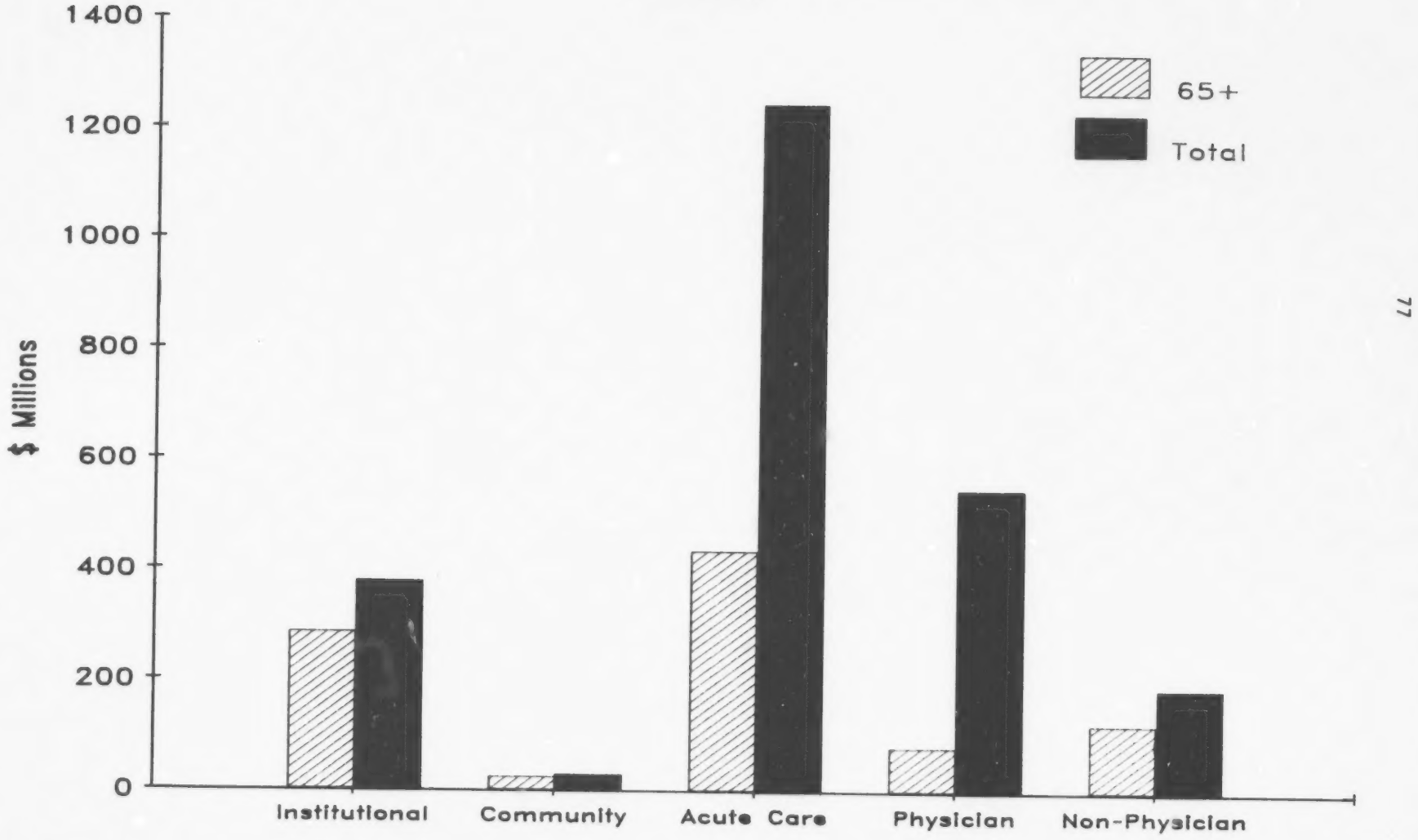
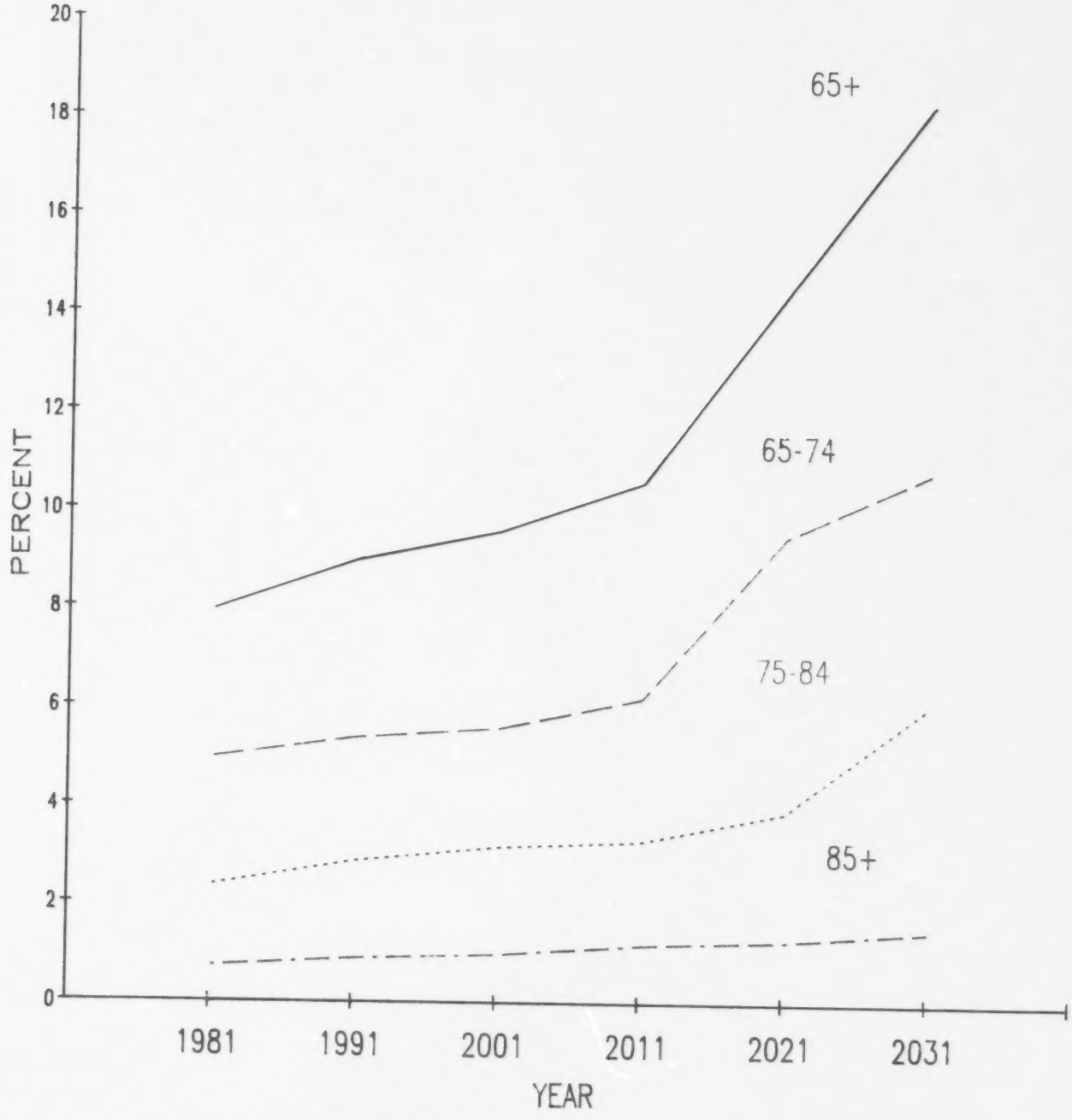


FIGURE 2-4
PERCENTAGE OF POPULATION 65+ BY AGE CATEGORY IN ALBERTA 1981 - 2031



SOURCE: Alberta Bureau of Statistics, August 1987

FIGURE 2-5
INCREASE IN POPULATION 65+
BY DISCRETE AGE CATEGORY
1986 - 2031

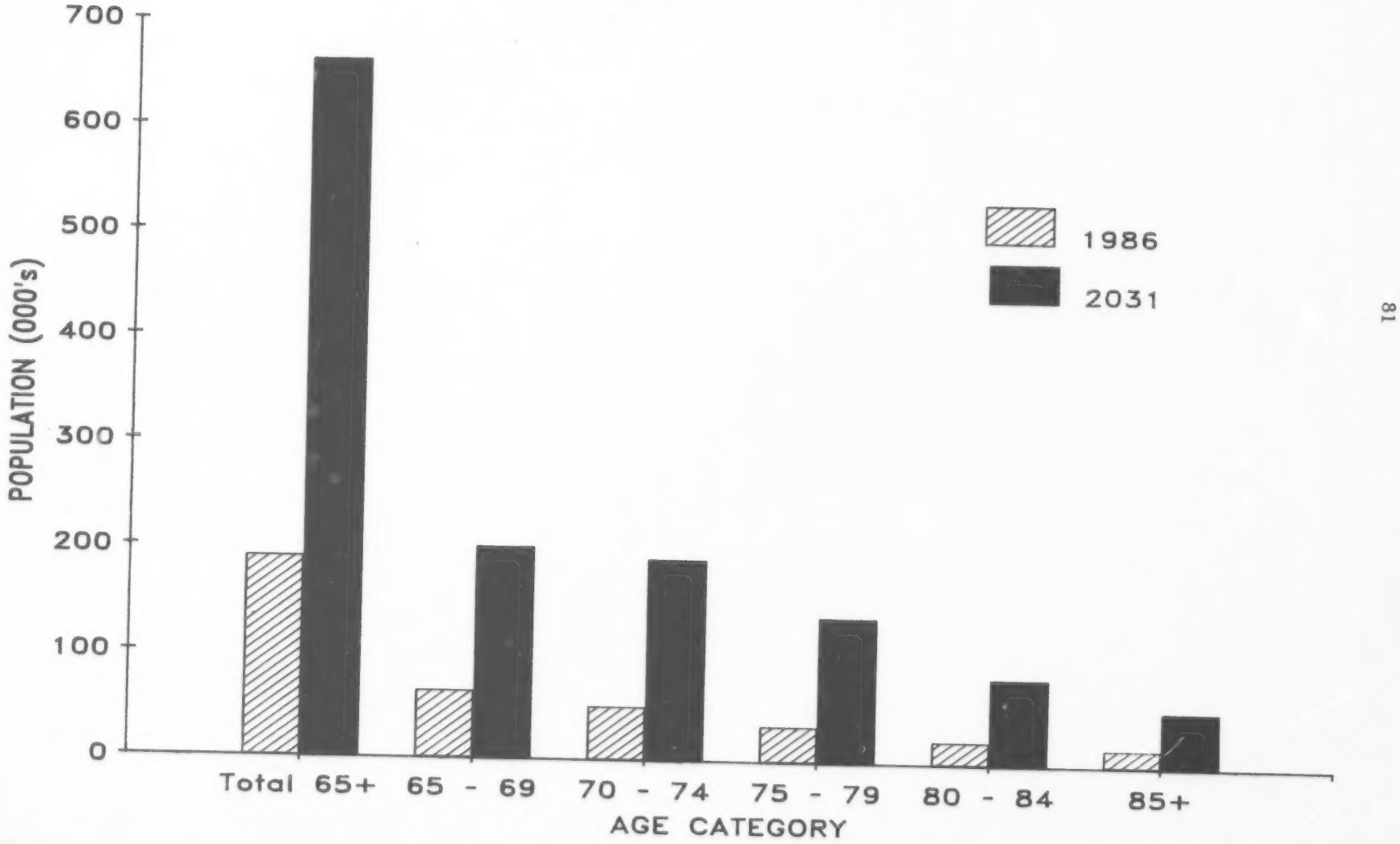


TABLE 2 - 3: COORDINATED HOME CARE PROGRAM, UTILIZATION AND FUNDING 1980/81 TO 1985/86

	Average Monthly Caseload	Total Cases Seen	Funding $ Million
1980/81	4,883 (1980)	not available	$10.5
1981/82	6,497 (1981)	not available	14.7
1982/83	7,192 (1982)	not available	16.5
1983/84	7,047 (1983)	17,917 (1983)	18.0
1984/85	7,763 (1984)	20,130 (1984)	22.5
1985/86	10,450	22,714 (1985)	27.0

Source: Alberta Community and Occupational Health, Home Care Unit.

TABLE 2 - 4: INCREASE IN BED SUPPLY IN LODGES, NURSING HOMES, AUXILIARY HOSPITALS AND ACUTE CARE HOSPITALS FOR THE YEARS ENDING MARCH 31, 1979 - 1986

Year	Nursing Home	Auxiliary Hospital	Acute Hospital	Lodges
1979	7,025	3,255	11,390	6,526
1980	7,132	3,513	11,389	6,949
1981	7,255	3,903	12,000	7,036
1982	7,286	4,213	12,266	7,164
1983	7,340	4,399	12,206	7,426
1984	7,590	4,780	12,159	7,923
1985	7,694	4,740	12,245	8,007
1986	7,808	4,900	12,328	8,090

Source: Alberta Hospitals and Medical Care. Annual Report for the years 1978/79 through 1985/86.
Alberta Mortgage and Housing Corporation, Portfolio Report: Senior Citizens Lodge Program as at August 31, 1987.

TABLE 2-5

INCREASE IN FUNDING FOR NURSING HOMES AND AUXILIARY HOSPITALS

1979/80 TO 1985/86

	Nursing Homes	Auxiliary Hospitals
1979/80	$49,910,814	$57,600,731
1980/81	57,822,292	69,450,060
1981/82	66,002,743	90,492,914
1982/83	85,648,505	128,003,807
1983/84	95,513,217	150,716,094
1984/85	104,651,151	164,527,913
1985/86	111,048,539	176,097,294

Source: Alberta Hospitals and Medical Care. Annual Report for the years ending 1979 - 1986.

TABLE 2 – 6: ELDERLY PERSONS SERVED IN LONG TERM CARE IN ALBERTA, 1985/86

A. Long Term Care Facilities			
Nursing Homes	6,682		
Auxiliary Hospitals	3,735		
Extended Care Centres[1]	397		
Sub-Total	10,814	36.1%	
B. Community Based			
Home Care[2]	12,364		
Day Care	120		
Day Hospital	107		
Sub-Total	12,591	42.1%	
C. Residential Facilities[3]			
Lodges	5,770		
Unique Homes	347		
"Other" Residential[4] Care Facilities	417		
Sub-Total	6,534	21.8%	
TOTAL		29,939	100%

1 Facilities in Claresholm, Rosehaven (Canmore), and Raymond.

2 Based on an active caseload of 14,212 clients, as of March 31, 1987, approximately 87% of which are classed as "long term".

3 Some of these residents may also be receiving community-based services.

4 Includes the following facilities: Canterbury Court, Edmonton (146 beds); Trinity Lodge, Calgary (170 beds); Ukrainian Home for the Holy Eucharist, Edmonton (42 beds, 3 vacancies); St. Joseph's Home for the Aged, Medicine Hat (67 beds, 4 vacancies).

TABLE 2 - 7: SENIORS IN ACUTE CARE HOSPITALS, 1985/86

	Cases	%	Patient Days	%	Average Length of Stay
0 - 64 years	370,975	(81%)	2,185,822	(64%)	5.89
65+	87,456	(19%)	1,247,217	(36%)	14.26
Total	458,431	(100%)	3,433,101	(100%)	7.49

- The elderly comprise approximately 36% of total patient days in acute care hospitals and 19% of total cases. This translates into approximately $473 million of a $1.3 billion budget for active care in 1985/86.

- The average length of stay for seniors is more than twice that for persons under 65.

Source: Alberta Hospitals and Medical Care
morbidity data file, 1985/86

TABLE 2-8 **EXPENDITURES FOR OTHER HEALTH CARE SERVICES AND BENEFITS, 1985/86**

	ALBERTA HEALTH CARE INSURANCE PLAN BASIC HEALTH SERVICES									
	PHYSICIAN PAYMENT†		PHYSIOTHERAPY		PODIATRY		CHIROPRACTIC		OPTOMETRY	
AGE GROUP	$	% OF TOTAL PAID	$	%	$	%	$	%	$	%
UNDER 65	467,741,283	85.06	12,810,489	85.7	1,664,819	47.8	19,230,225	90.1	8,157,737	90.2
65+	82,157,873	14.94	2,133,605	14.3	1,814,912	52.2	2,105,097	9.9	884,432	9.8
TOTAL	549,899,157	100	14,944,094	100	3,479,731	100	21,335,322	100	9,042,169	100

	EXTENDED HEALTH BENEFITS* - DENTAL AND OPTOMETRIC		BLUE CROSS NON-GROUP**		EXTENDED BENEFITS - AIDS TO DAILY LIVING***	
AGE GROUP	$	%	$	%	$	%
UNDER 65	5,033,413	16.5	16,906,427	19	-	-
65+	25,549,185	83.5	72,462,818	81	20,000,000	-
TOTAL	30,582,598	100	89,369,245	100	20,000,000	100

* Includes registrant or spouse 65+ and their dependants as well as widows/widowers group.

** Includes registrant or spouse 65+ and their dependants.

*** Administered by Community and Occupational Health. Includes registrants or spouse 65+ and their dependants as well as widows/widowers group.

SOURCE: Alberta Hospitals and Medical Care, Unpublished Data.

TABLE 2-9
LONG TERM CARE PROGRAM DESCRIPTIONS

	HOME CARE	DAY CARE	DAY HOSPITAL	LODGE	NURSING HOME	AUXILIARY HOSPITAL
SERVICES PROVIDED	Comprehensive assessment, case management, and home delivered health and support services.	Social opportunities and care on a daily basis in a group setting to frail and disabled elderly persons.	Nursing and rehabilitation therapy and socialization opportunities on a daily basis.	Room and board to seniors.	Personal care with nursing supervision, room and board.	Skilled nursing and medical services, room and board.
AVERAGE COST PER DAY (GOVERNMENT PORTION)	100% funding for health and personal care services and approximately 98% of total cost of program which was $2.7M in 1985/86. The average cost per client per year was $1,066.00. The actual cost of delivering support services is approximately $11.00/hour.	$22 per space	Cost varies depending on volume. Approximately $50 per day based on a volume of 20 clients over 250 operating days.	$19.81 per resident (total expense) Government (AMHC and the municipalities) fund only the operating deficit which was $6.15 (average cost per resident day per lodge) in 1985.	Per diem rates 0 - 45 beds $39.00 46 - 90 beds $36.50 over 90 beds $36.00	Approximately $113.00 per patient day, in government operating grants.
USER CHARGES	No charge for health and personal care services. User fee of $2.00/hour or $2.00/meal for support services (homemakers, meals-on-wheels, handyman) to a maximum of $300/month. There is no charge for the first two weeks on the program. Clients on G.I.S., Social Allowance and Widow's Pension are exempt.	$3.00 per day	All or portion of transportation and meal costs (usually $3.50/meal).	Maximum Rates Effective April 1, 1987: Single: - $440/month or $14.19/day Double: - $396/month or $12.77/day Special Single: - $515/month or $16.61/day	Daily Accommodation Charges: $14.00 Standard $16.50 Semi-Private $20.25 Private	Daily Accommodation Charges After 120 Days Stay: $14.00 Standard $20.25 Private

TABLE 2 - 10:
ALBERTA POPULATION PROJECTION
BY AGE GROUPS, 1986 - 2031
(PERCENT)

YEAR	0 - 14	15 - 24	25 - 44	45 - 64	65+
1986[1]	23.7	17.2	34.4	16.5	8.1
1996[1]	23.8	14.4	35.8	17.2	8.8
2001[1]	20.1	15.0	32.8	22.6	9.5
2011[1]	17.2	13.9	30.4	28.0	10.5
2012[1]	17.2	13.5	30.5	27.9	10.8
2013[1]	17.2	13.2	30.6	27.9	11.2
2014[1]	17.1	12.9	30.7	27.8	11.5
2015[1]	17.1	12.6	30.7	27.8	11.8
2016[1]	17.1	12.3	30.7	27.7	12.1
2017[1]	17.1	12.1	30.7	27.6	12.5
2018[1]	17.1	11.9	30.7	27.4	12.9
2019[1]	17.1	11.7	30.6	27.2	13.4
2020[1]	17.0	11.6	30.5	27.0	13.9
2021[1]	16.9	11.6	30.4	26.7	14.4
2022[1]	16.9	11.5	30.2	26.5	14.9
2023[1]	16.7	11.5	30.1	26.2	15.4
2024[1]	16.6	11.5	29.9	26.0	15.9
2025[1]	16.5	11.6	29.7	25.9	16.4
2026[1]	16.4	11.6	29.4	25.8	16.8
2027[1]	16.2	11.7	29.1	25.7	17.2
2028[1]	16.1	11.7	28.8	25.8	17.6
2029[1]	15.9	11.8	28.5	25.9	17.9
2030[1]	15.8	11.8	28.0	26.3	18.2
2031[1]	15.7	11.9	28.0	26.3	18.2

Notes: 1. These projections are based on projection Series II, Bureau of Statistics' Long-Term Population projections, released in March, 1987.
2. Migration is assumed to be constant at 20,000 persons per year starting in 1996.
3. Fertility is assumed to be constant, at 1.6 births per woman age 15 - 49 after 2001.
4. Survival rates are based on 1981 census information.
5. Totals may not add up due to rounding.

Source: Alberta Bureau of Statistics, Aug., 1987.

TABLE 2 - 11: INCREASE IN POPULATION AGED 65 AND OVER BY DISCRETE AGE CATEGORY BETWEEN 1986 TO 2031

	65+ Total	65 - 69	70 - 74	75 - 79	80 - 84	85+
1986	191,300	65,100	51,400	34,800	22,600	17,400
2031	663,100	201,300	190,800	137,500	81,500	52,000
Percentage increase between 1986 and 2031	246%	209%	271%	295%	260%	199%

Source: Alberta Bureau of Statistics, August, 1987.

TABLE 2-12
ALBERTA POPULATION PROJECTION FOR AGE 65 AND OVER, 1986-2031
(POPULATION IN THOUSANDS)

Year[1]	Total	65+	65-69	70-74	75-79	80-84	85+
1986	2365.8	191.3	65.1	51.4	34.8	22.6	17.4
1996	2503.1	220.0	74.1	56.7	34.8	22.6	17.4
2001	2852.9	270.9	85.0	71.4	53.3	34.1	27.1
2011	3178.0	333.0	114.3	80.4	60.9	42.7	34.5
2012	3209.4	347.2	124.3	83.4	60.9	43.1	35.0
2013	3240.7	361.2	132.5	87.7	61.7	43.8	35.7
2014	3271.5	374.9	139.8	91.9	62.8	44.0	36.4
2015	3301.7	389.2	147.6	96.1	64.2	44.0	37.4
2016	3331.2	404.1	155.4	100.3	66.1	44.3	38.1
2017	3359.9	419.7	159.0	109.0	68.4	44.7	38.6
2018	3387.7	437.4	164.7	116.3	72.0	44.9	39.2
2019	3414.5	456.8	173.4	122.6	75.5	45.8	39.5
2020	3440.3	177.3	182.3	129.4	78.9	46.8	40.4
2021	3465.1	498.3	191.2	136.1	82.3	48.2	40.4
2022	3488.8	519.5	199.9	139.2	89.6	50.0	40.8
2023	3510.4	541.0	206.9	144.5	95.6	52.6	41.3
2024	3531.0	561.8	212.0	151.9	100.8	55.2	41.8
2025	3550.4	582.2	215.9	159.7	106.3	57.7	42.6
2026	3568.7	600.9	217.8	167.5	111.7	60.1	43.7
2027	3585.9	618.0	218.2	175.1	114.2	65.6	44.9
2028	3602.2	633.6	217.1	181.3	118.6	70.1	46.7
2029	3617.4	646.5	214.0	185.7	124.7	73.8	48.4
2030	3631.7	655.4	207.4	189.1	131.1	77.6	50.1
2031	3645.2	663.1	201.3	190.8	137.5	81.5	52.0

NOTES:

1. These projections are based on projection Series II, Alberta Bureau of Statistics' long-term population projections, released in March, 1987.
2. Migration is assumed to be constant at 20,000 persons per year starting 1996.
3. Fertility is assumed to be constant, at 1.6 births per woman age 15-49, after 2001.
4. Survival rates are based on 1981 census information.
5. For 1986, age groups 75-79, 80-84 and 85+ are estimated, as only population 75+ is currently provided by census data.
6. Totals may not add up due to rounding.

SOURCE: Alberta Bureau of Statistics, August, 1987.

TABLE 3 - 1

AVERAGE AGE AT ADMISSION TO NURSING HOMES, AUXILIARY HOSPITALS, AND LODGES

	Nursing Homes	Auxiliary Hospitals	Lodges
1978/79	79.09	73.61	77.31
1979/80	78.92	75.10	
1980/81	79.46	75.07	
1981/82	79.56	75.57	
1982/83	79.11	75.23	
1983/84	79.18	75.32	
1984/85	79.66	75.31	
1985/86	80.12	75.71	77.6*

* Data on average at admission to lodges was unavailable for the years given. In addition, the average age of persons leaving lodges was 78.6 in 1985/86.

TABLE 3 - 2

AVERAGE AGE OF NURSING HOME AND AUXILIARY HOSPITAL PATIENTS 1979 - 1986

	Nursing Homes (at year-end)	Auxiliary Hospitals (at fiscal year-end)
1979	80.00	75.61
1980	79.99	76.27
1981	80.20	76.39
1982	80.32	76.27
1983	80.20	76.28
1984	80.34	76.58
1985	80.56	77.27
1986	80.65	77.68

TABLE 3 - 3: LIFE EXPECTANCY BY SEX AT BIRTH, 65 YEARS, AND 85+ YEARS IN ALBERTA, 1965-67 TO 1980-82

	MALE	FEMALE
AT BIRTH		
1965-67	70.10	76.24
1970-72	70.42	77.30
1975-77	71.07	77.92
1980-82	71.96	79.06
AT 65 YEARS		
1965-67	14.46	17.34
1970-72	14.64	18.24
1975-77	14.74	18.35
1980-82	14.98	19.17
AT 85+ YEARS		
1965-67	5.02	5.39
1970-72	5.00	6.05
1975-77	5.08	5.59
1980-82	4.74	6.00

Source: Statistics Canada, Life Tables Canada and Provinces
- 1965/67: Cat. No. 84-527 Occasional, January 1971.
- 1970/72: Cat. No. 84-532 Occasional, October 1974.
- 1975/77: Cat. No. 84-532 Occasional, October 1979.
- 1980/82: Cat. No. 84-532 Occasional, May 1984.

TABLE 3 - 4: REPORTED INCOME LEVEL OF PERSONS AGED 55 AND OVER BY AGE GROUP AND SEX, ALBERTA, 1981[1]

Income	Age Group									
	55 - 64		65 - 74		75 - 84		85+		65+	
	M	F	M	F	M	F	M	F	M	F
	%	%	%	%	%	%	%	%	%	%
<$7,00	9	11	11	20	18	37	15	35	13	25
$7,000-11,999	7	14	25	28	38	22	35	20	29	26
$12,000-19,999	17	20	26	22	22	17	21	16	25	20
$20,000-29,999	22	22	18	14	8	10	7	12	14	13
>$30,000	45	33	20	16	14	14	22	17	19	16
	100	100	100	100	100	100	100	100	100	100
TOTAL NUMBER	1478	1546	896	1019	383	441	58	85	1337	1545

Source: Canadian Association on Gerontology 2% Sample Tape of the Canadian Population Over the Age of 55 Years, 1985 (based on 1981 census data).

[1] This information was not obtained from persons in collective dwellings, i.e., institutions, colonies, chronic care facilities, nursing homes, homes for the aged.

TABLE 10-1

COMPARISON OF SERVICES PROVIDED IN NURSING HOMES AND AUXILIARY HOSPITALS

SERVICES PROVIDED	NURSING HOMES	AUXILIARY HOSPITALS
Nursing Hours	° Average 1.65 worked hours	° 3.6 paid hours (may go up to 4.0, based on specific conditions).
R.N. Coverage	° R.N. on call for 24 hours for smaller nursing homes, R.N. on duty for 24 hours for larger nursing homes.	° R.N. on duty 24 hours
Physiotherapy	° Included	° Some also provide active rehabilitation for short term cases.
Recreation Therapy	° Included	° Included
Physician Services	° Medical Advisor ° Physician paid by AHCIP when called to provide service.	° Organized medical staff ° Physician paid by AHCIP on a per diem basis for days in hospital (to maximum). ° Sessional payments covered by some institutions.
Drugs	° Not supplied by facility; when covered by Blue Cross, user pays 20%.	° Supplied by facility
Transportation/ Ambulance	° Covered by Blue Cross; user pays according to Blue Cross arrangement.	° Facility pays for transfer.
Diagnostic Assessment	° Referred to acute care hospitals, as outpatient services.	° Provided on site or transported to acute care hospital for services.

TABLE 10-2
INTERPROVINCIAL COMPARISON OF LONG-TERM CARE BEDS, 1986

TYPE OF BED	NFLD. & LAB.	P.E.I.	N.S.	N. B.	QUE.	ONT.	MAN.	SASK.	ALTA.	B. C.
A. EXTENDED CARE[1] (Extended Care/ Chronic/Auxiliary)	266	73	355	587	15,055	11,836	945	641	4,673	7,009
Per 1000 Pop.	.45	.56	.40	.81	2.27	1.28	.87	.63	1.95	2.4
Per 1000 Pop. 65+*	5.3	4.6	3.4	7.4	23.0	11.8	6.9	5.0	24.2	19.7
B. INTERMEDIATE CARE[2] (Nursing Homes, Special Care Home, Homes For The Aged)	3,127	1,078	6,267	5,610	32,329	58,701	8,153	8,839	8,644	18,282
Per 1000 Pop. 65+	62.0	67.3	60.5	71.0	49.2	58.3	60.0	69.0	44.8	51.4
TOTAL BEDS	3,393	1,151	6,622	6,197	57,384	70,537	9,098	9,480	13,317	25,291
BEDS PER 1000 65+	67.3	71.9	63.9	78.4	72.2	70.1	66.9	74.0	69.0	71.1

SOURCES: (a) "Directory of Long-Term Care Centres in Canada, 1986"; Canadian Hospital Association.
(b) "Canadian Hospital Directory, 1986", Vol. 33; Canadian Hospital Association.
(c) Statistics Canada. "Postcensal Annual Estimates of Population by Marital Status, Age, Sex and Components of Growth For Canada, Provinces and Territories, June 1, 1986"; Vol. 3, Third Issue. The Population Figures contained in this table are not the 1986 census results, but in fact estimates based on the 1981 census counts (Alberta population 65+ 193,000; total population 2,389,500).

* The difference in the levels of care provided in the categories of Extended Care and Intermediate Care accounts for the substantial interprovincial variation in the ratios of Extended Care beds/1000 population 65+, while the total bed/1000 population ratios exhibit very little variation.

NOTES:

1 Includes beds provided for geriatric, chronic, extended, auxiliary and veterans care, and beds for other long-term or chronic illnesses found in both general and specialty hospitals and extended care facilities.

2 Includes beds in public and private long-term care facilities which focus primarily on care for the elderly and are designed to offer some level of residential, supervisory, personal, or nursing care. Beds designated for psychiatric care, emotionally disturbed children, alcoholic rehabilitation, and the mentally handicapped have been excluded, as have lodge beds.

TABLE 10-3
COMPARISON OF THE PERCENTAGE OF ELDERLY IN INSTITUTIONS 1980/81, 1985/86
ALOS = Average Length of Stay
N/A = Data Not Available
Age is Age at Admission

AUXILIARY CARE BEDS

	1980/81			1985/86		
AGE GROUP	CASES	ALOS	% OF AGE GROUP	CASES	ALOS	% OF AGE GROUP
0 - 64	627	1,384	0.03	799	1,045	0.04
65 - 74	587	1,105	0.58	837	749	0.73
75 - 84	1,062	1,051	2.18	1,570	714	2.65
85+	882	951	6.22	1,328	605	7.42
TOTAL	3,158	1,010	0.14	4,534	753	0.19
TOTAL 65+	**2,531**	**1,029**	**1.55**	**3,735**	**683**	**1.94**

NURSING HOMES

	1980/81			1985/86		
AGE GROUP	CASES	ALOS	% OF AGE GROUP	CASES	ALOS	% OF AGE GROUP
0 - 64	965	1,940	0.05	904	2,520	0.04
65 - 74	1,353	1,383	1.35	1,325	1,526	1.15
75 - 84	2,787	1,119	5.73	3,072	1,054	5.19
85+	1,926	850	13.59	2,285	833	12.76
TOTAL	7,031	1,208	0.31	7,586	1,244	0.32
TOTAL 65+	**6,066**	**1,092**	**3.71**	**6,682**	**1,072**	**3.47**

TOTAL AUXILIARY HOSPITALS AND NURSING HOMES

	1980/81			1985/86		
AGE GROUP	CASES	% OF AGE GROUP	% OF USERS	CASES	% OF AGE GROUP	% OF USERS
0 - 64	1,592	0.08	15.62	1,703	0.08	14.05
65 - 74	1,940	1.93	19.04	2,162	1.87	17.84
75 - 84	3,849	7.91	37.78	4,642	7.84	38.30
85+	2,808	19.81	27.56	3,613	20.18	29.81
TOTAL	10,189	0.46	100.00	12,120	0.51	100.00
TOTAL 65+	**8,597**	**5.26**	**84.38**	**10,417**	**5.41**	**85.95**

TABLE 10-4
NUMBER OF PATIENTS IN ACUTE CARE WAITING FOR LONG TERM CARE BEDS[1]
(AS OF JUNE, 1987)

REGION	NUMBER	% ACUTE CARE BEDS[2]
Calgary	131	4.4
Edmonton	304	7.8
Peace River	27	3.8
North East Alberta	2	0.6
Edmonton Area	69	6.8
Edson/Hinton	0	0
Lloydminster/Camrose	58	10.8
Red Deer*	37	5.5
Calgary Area*	21	3.7
Lethbridge*	30	3.7
Medicine Hat	22	5.3
TOTAL	702	5.7%

1 Assessed and waiting for transfer according to waiting list data. This is a minimum. Some long-term care facilities contacted were unsure of the exact number of patients, if any, in acute care.

2 As most patients on the waiting list are from the acute care facilities in the same region, the percentages indicate the extent of long-term care patients occupying acute care beds. As there are no long-term care beds in Ft. Vermilion/High Level, that region is excluded from the list.

* Still waiting to hear from at least one facility in each of these regions.

TABLE 11-1

NUMBER OF PERSONNEL PROVIDING DIRECT CARE IN SELECTED SETTINGS BY MANPOWER GROUP AND EMPLOYER CATEGORY

MANPOWER GROUP	AUXILIARY HOSPITAL	NURSING HOMES	ADULT CARE CENTRES[a]	COMMUNITY HEALTH NURSING[b]		HOME CARE PROGRAM[b]	GENERAL HOSPITALS	SUB TOTAL
NURSING PERSONNEL								
Registered Nurses	1,030	905	54	590	149[c]	406	10,145	13,279
Psychiatric Nurses	16	8	41	-	-	-	86	151
Graduate Nurses	14	77	1	-	43[c]	-	48	183
Registered Nursing Assistants	883	422	-	-	24[c]	-	2,416	3,745
SUB TOTAL	1,943	1,412	96				12,695	17,358
REHABILITATION PERSONNEL								
Physical Therapists	52	39	-	-	-	28[d]	357	476
Occupational Therapists	37	37	2	-	-	16[d]	161	253
Speech Pathologists and Audiologists	4	-	-	-	76[e]	-	102	180
SUB TOTAL	93	76	2				620	909
SOCIAL SERVICES PERSONNEL								
Recreational Therapists	45	52	2	-	-	-	43	142
Social Workers	19	-	5	-	-	10[d]	189	223
SUB TOTAL	64	52	7				232	365
DIETARY PERSONNEL								
Dietitians	25	42	2	-	-	-	167	236
Nutritionists	-	-	-	-	-	17[d]	5	22
Dietary Technicians	34	69	1	-	-	-	126	230
SUB TOTAL	59	111	3			17	298	488
PHARMACY PERSONNEL								
Pharmacists	23	-	2	-	-		215	240
SUB TOTAL	23	-	2				215	240

Source: See notes on following page.

Continued

MANPOWER GROUP	AUXILIARY HOSPITAL	NURSING HOMES	ADULT CARE CENTRES[a]	COMMUNITY HEALTH NURSING[b]		HOME CARE PROGRAM[b]	GENERAL HOSPITALS	SUB TOTAL
HOME CARE PERSONNEL								
Homemakers	12	-	-	-	-	175[d]	-	187
Homehelpers	-	29	-	-	-	29[d]	9	67
Personal Care Attendants	-	-	-	-	-	14[d]	-	14
SUB TOTAL	12	29	-			218	9	268
INSTITUTIONAL AIDES								
Nursing Attendants	1,025	2,551	189	-	-	3[d]	903	4,671
Dietary Aides	487	855	57	-	-	-	1,777	3,176
Recreational Therapy Aides	69	144	13	-	-	-	20	246
Physical Therapy Aides	41	12	-	-	-	-	79	132
Social Service Aides	1	1	-	-	-	-	2	4
Occupational Therapy Aides	20	1	21	-	-	1[d]	33	76
SUB TOTAL	1,643	3,564	280	-	-	4	2,814	8,305
GRAND TOTAL	3,837	5,244	390				16,883	27,933
TOTAL NUMBER SERVED	BEDS	BEDS	BEDS	INDIVIDUALS		INDIVIDUALS	IN-PATIENTS	

Source: "Health and Social Services Personnel Working in Alberta", Edmonton, Alberta: Alberta Health and Social Services Disciplines Committee, December 1986.

a Excludes Raymond Adult Care Centre which has a minimal number of elderly patients.

b The Alberta Health and Social Services Disciplines Committee employer survey is directed to health units. With the exception of registered nurses working in community health nursing and home care, the questionnaire does not distinguish which personnel are employed within each program. Other programs which are provided through health units but not commonly used by the elderly are: Family Planning; Alberta Heredity Diseases Program, Early Intervention and Speech Pathology and Audiology.

c The survey does not indicate which programs within the health unit these individuals serve.

d Based on the nature of the service, it can be assumed that these individuals are employed in the home care program although survey data only indicate they are employed in health units.

e Probably employed in the Speech Pathology and Audiology Program.

TABLE 11-2

ESTIMATED NUMBER OF HEALTH CARE PRACTITIONERS SERVING THE ELDERLY THROUGH THE ALBERTA HEALTH CARE INSURANCE PLAN BASIC HEALTH SERVICES[1]

	Age Group	Service	% of Total Paid	Number of Practitioners
Physicians	UNDER 65	21,737,400	85	
	65+	3,826,123	15	
	TOTAL	25,563,523	100	3,554
Physical Therapists	UNDER 65	6,774,101	86	
	65+	1,150,122	14	
	TOTAL	7,924,223	100	355
Podiatrists	UNDER 65	64,225	52	
	65+	59,625	48	
	TOTAL	123,850	100	18
Chiropractors	UNDER 65	1,645,033	90	
	65+	180,671	10	
	TOTAL	1,825,704	100	323
Optometrists	UNDER 65	343,538	90	
	65+	37,242	10	
	TOTAL	380,780	100	213

Source: Health Care Services for the year ending March 31, 1986, Alberta Hospitals and Medical Care, unpublished data.

[1] Estimates are based on the proportion of services used by the elderly.

TABLE 11-3

NUMBER OF HEALTH AND SOCIAL SERVICE PERSONNEL PRACTISING IN ALBERTA, 1986[1]

* Physicians		
General Practitioners	2,053	
Specialists	1,853	3,906
Nursing Personnel		
Registered Nurses	15,498	
Registered Nursing Assistants	3,393	
Registered Psychiatric Nurses	703	20,140
Rehabilitation Personnel		
Physical Therapists	844	
Occupational Therapists	330	
Speech Pathologists & Audiologists	330	1,504
Social Services Personnel		
Social Workers	2,154	
Recreational Therapists	207	2,361
Dental Personnel		
*Dentists	1,224	
Dental Hygienists	601	
Denturists	215	
Dental Assistants	1,983	4,023
Pharmacy Personnel		
Pharmacists	1,852	
Pharmacy Technicians	394	2,246
Dietary Personnel		
Dietitian/Nutritionists	307	
Dietary Technicians	248	2,801
*Other Health Care Personnel		
Optometrists	211	
Opticians	340	
Chiropractors	316	
Podiatrists	19	886

[1] "Health and Social Services Personnel Working in Alberta": Alberta Health and Social Services Disciplines Committee, December 31, 1986.

* Refers to the number of personnel registered with their professional association but not necessarily practising.

APPENDIX II

GLOSSARY OF TERMS

Alberta Patient Classification System For Long-Term Care Facilities	is a system for grouping residents/patients into classification categories which are rank ordered in terms of amount of nursing resources required. This system is for funding patient care services in nursing homes and auxiliary hospitals on the basis of relative case mix of resident/patients in one facility as compared to the long-term care facilities in the province.
Adult Day Programs	are organized group programs offering varying degrees of therapeutic, rehabilitative and personal care, as well as opportunities for socializing and recreation, on a daily non-resident basis.
Auxiliary Hospitals	are designed and operated for persons usually chronically ill or disabled, who require a less intensive level of care than is provided in acute care hospitals. For some, treatment consists of rehabilitation to a point where return to the community or transfer to a nursing home or other residential facility is possible. For others, nursing and medical care is provided for an extended period, even though there is little prospect of rehabilitation.
Lodge	is a facility for the elderly, providing accommodation, meals and housekeeping.
Long Term Care	in this report refers to any professional or personal service required by an individual on a recurring or continuous basis because of chronic physical or mental impairment. It may be provided in a variety of settings, including the client's home, and seniors' apartments or in lodges.
Long Term Care Centre	is a term used in this report to describe a single institutional system including nursing homes, auxiliary hospitals and extended care centres (Rosehaven, Raymond and Claresholm).

GLOSSARY - Con't.

Multi-Level Care Facility	is, for the purposes of this report, defined as one which combines on the same or contiguous sites, under one management, programs drawn from at least two of the following three categories: nursing homes and auxiliary hospitals, housing for senior citizens (lodges, self-contained apartments), and care and support services to persons living in the community (e.g., day care).
Nursing Home	provides supervised, personal care for people who are not ill enough to require hospitalization in an acute care or auxiliary hospital, but require assistance with the activities of daily living. There are three kinds of nursing home ownership in Alberta - private, voluntary and district. A private nursing home is one owned and operated by an Alberta company, body corporate, corporation or extra-provincial corporation as defined in the Business Corporation Act. A voluntary nursing home is owned or operated by a society. A district nursing home is owned and operated by a district board.
Palliative Care	provides physical, psychological, social and spiritual support when treatment aimed at curing is no longer appropriate. It may be provided in a hospital, nursing home, or at home, and, in the final stages, concerns itself with needs of the dying and their families.
Psychogeriatric	is a branch of medicine that deals with the problems and diseases of aging people who are suffering from a defective or lost contact with reality.
Public Nursing Home	see Nursing Home, District
Respite Beds	also known as relief beds, are available on a temporary basis in a nursing home. These are usually used for an elderly person whose family is going on holiday, or when the caregiver is ill or needs rest. These beds may also be used for pre-admission orientation.